DCF LEGISLATIVE BRIEFING BOOKLET

LEGISLATIVE HEARING
October 20, 2008

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I. INTRODUCTION AND AGENCY OVERVIEW

The purpose of this document is to present information regarding the Connecticut Department of Children and Families (DCF) - its mandates, its activities, and its performance. As a complex human services organization there are many aspects of our work to be explored and examined. This Briefing Booklet contains information related to several important conditions of child welfare and child well-being in Connecticut, but has been scoped in response to matters that are the subject of this legislative hearing.

Before delving into each of these areas, it is important to understand the broader context within which DCF conducts its work and view each of the above subject areas as part of the larger agency mission and plan of development. Formed in 1974 as a consolidated children's agency, DCF has broad authority and primary responsibility for state mandates concerning child protection, children's behavioral health, juvenile delinquency, and prevention services related to children and families. Its mission and statutory mandates are as follows:

MISSION

> *The mission of the Connecticut Department of Children and Families is to protect children, improve child and family well being and support and preserve families. These efforts are accomplished by respecting and working within individual cultures and communities in Connecticut, and in partnership with others.*

STATUTORY MANDATES

Behavioral Health Services: The Department operates Riverview Hospital for Children and Youth, High Meadows Residential Treatment Center, and the Connecticut Children's Place. Through Connecticut Community KidCare, the Department also provides funding for a broad array of clinical and other services in the community, including outpatient clinics for children, therapeutic group homes, extended day treatment programs, emergency mobile psychiatric services, respite care, family advocacy, intensive case management and much more.

Child Welfare Services: DCF's child welfare mandate requires the Department to investigate all accepted reports of alleged child maltreatment and to provide services to all children found to be in such a condition. There are 14 area offices located throughout Connecticut. DCF operates a 24 hour Hotline to receive calls from people with questions, concerns, and reports of child abuse and neglect. The Hotline also provides evening, weekend, and holiday investigation responses to immediate situations concerning abuse and neglect of children. In addition, the Department is responsible for foster care services that provide a family environment for children who are temporarily unable to live in their biological homes. Together with other services provided to foster parents, families and children, these homes facilitate the reunification of children with their families or establish another permanent family for the children.

Juvenile Services: Juvenile services seek to develop competency, accountability, and responsibility in all programs and services through the Balanced and Restorative Justice model (BARJ) – with the ultimate goal of each child achieving success in the

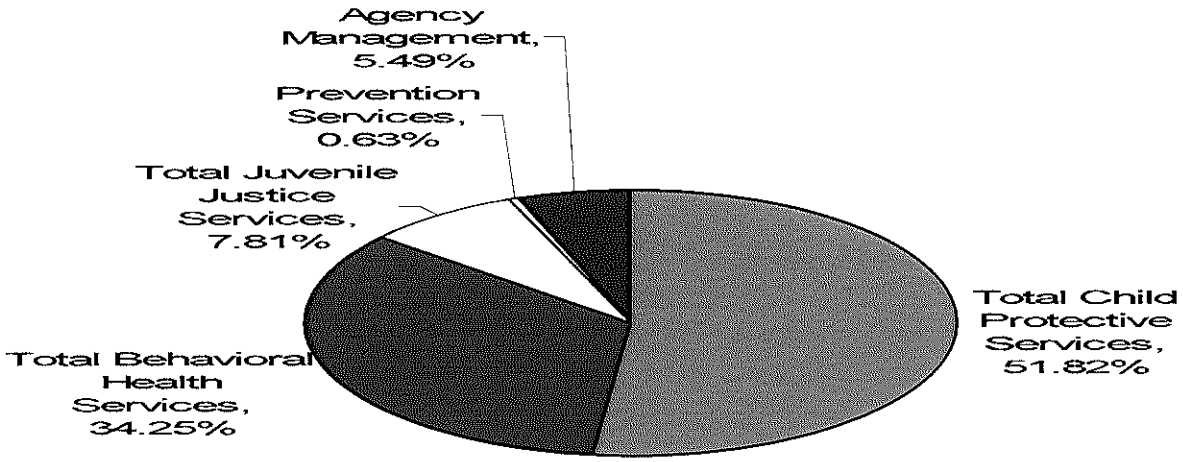
community. Juvenile services offer programming through community-based services, private residential treatment, and state-operated facilities. Juvenile services collaborate with community providers, public and private agencies, families and educational agencies to individualize the treatment for each child based on the child's strengths, culture and ethnicity, and gender, while maintaining community safety.

Prevention: DCF's prevention mandate is to promote a range of services that enable children and families to thrive independently in their communities and to apply evidence-based or best practice prevention approaches at strategic points in the DCF continuum of care. This work aims to ensure a smooth, timely and sustained transition for children, youth and families from DCF involvement to a state of independence and well being or to prevent DCF involvement altogether.

DCF BUDGET

Considerable resources have been committed to DCF and to programs and services that support Connecticut children and families. As one of the largest state agencies, our resource highlights include:

- Average number of full time employees: 3,477
- Recurring Operational Expenses: $838,837,437



A vast amount of DCF resources are used to purchase services for children and families. There are over 100 Service Types and a range of other purchases made through Flex Funding, including mentoring, respite services, wrap services, housing expenses, and therapeutic and recreational activities for children and youth in out-of-home care. Contracted Services in FY08 totaled $204 Million and an additional $103 million in Fee- For-Service program spending for a total of $298 Million. An additional $193 Million is spent through DCF's Board and Care Accounts for Adoption and Foster Care subsidy payments, no nexus education costs, and Flex Fund spending for a total of **$491 Million in purchased services.** There were 153 contracts entered in SFY 08.

A breakdown of the major functional areas of spending are as follows:

Program	Expenditures
CPS Community Based Services	$27,611,478
CPS Out of Home Services	$237,561,967
CPS Administration	$169,514,306
Total Child Protective Services	$434,687,751
BH Community Based Services	$68,979,335
BH Out of Home Services	$153,248,194
BH State Operated Facilities	$59,724,829
BH Administration	$5,298,338
Total Behavioral Health Services	$287,250,697
JJ Community Based Services	$17,664,484
JJ Out of Home Services	$18,222,455
JJ State Operated Facilities	$27,658,288
JJ Administration	$1,956,953
Total Juvenile Justice Services	$65,502,180
Prevention Services	$5,285,352
Agency Management (Personnel and Operating Expenses, etc)	$46,037,544
Total Agency Expenditures	$838,763,524

Over time, state appropriations committed to the work at the Department have grown significantly. Since FY 2004, there has been a 38 percent increase in DCF's budget growing from $607,484, 396 to its current budget of $838,763,524. These increases have primarily supported the following:

1) Increases in Personnel Services spending were largely driven by the hiring of social workers so that caseloads can be reduced--a prerequisite to improving practice and outcomes. Caseloads have been reduced to 15 to 20 per worker from 40 to 60 per worker in just a few years.

2) Increases in behavioral health spending helped build an important community based system of care, most notably in-home services which have allowed DCF to dramatically reduce its entry into care rate and expand access to behavioral health services.

3) Flex Fund spending has increased, and this has allowed for services to be far more individualized and immediate--an important departure from the categorical approach historically taken with families. Spending in this area has been linked to improving permanency, placement stability, and treatment outcomes. Most recently, the CFSR noted this as a system's strength in CT and was cited in several cases as having made a real difference for children and families.

4) Therapeutic Group Homes are a community-based congregate setting and have served as a key alternative to individuals that would otherwise be placed in large institutional settings. Since developing these group homes, our placement in out-of-state residential facilities has dropped from over 500 to less than 335 in three years. Even more important, the use of residential settings is down nearly 40 percent in 4 years due to this and other reform efforts.

5) Major investments have been made in the use of evidence-based and promising practices in the areas of child welfare, mental health, substance abuse treatment and family support.

FEDERAL REVENUE GENERATED BY DCF PROGRAMS

The largest source of federal revenueis Title IV-E claiming for eligible foster care and adoption payments, as well as our administrative claim for case management and training costs. In SFY08, total IV-E claiming totaled $123.9 million. In addition, the portions of administrative, training, and investigations costs that cannot be billed to IV-E are also considered for TANF. DCF spending claimed by DSS for TANF totaled $130 million in FFY'07. Also, a small portion of the social worker and health advocate costs are claimed as Medicaid EPSDT services. Below are the major areas of claiming.

- Riverview Hospital: DSS sets a Medicaid rate for Riverview, which is billed for Medicaid-eligible patients. Medicaid FFP for State Fiscal Year 2008 was approximately $11 million.
- Residential: Our residential rate is divided into a room and board portion (which is billed to Title IV-E for eligible children) and a clinical portion (which is billed to Title XIX for Medicaid eligible children, under PNMI). Federal Title IV-E Revenue is approximately $11 million per year, Medicaid Revenue is approximately $7 million per year. In addition, approximately $1 million per year in TANF revenue is generated for room & board costs for certain non-IV-E eligible children.
- Therapeutic Group Homes: The grant payment is divided into room and board and clinical portions and billed to Medicaid or Title IV-E - as with residential programs. Federal revenue for State fiscal year 2008 was approximately $1 million in Title IV-E and $2 million in Medicaid, however significant increases in federal revenue are anticipated for this level of care.

- Shelters, Safe Homes, Short-term Assessment and Respite services, and Level 1.5 Group Homes: Payments for room and board are billed to Title IV-E for Title IV-E eligible children. These services account for approximately $5 million in Title IV-E FFP.
- Expenses for Parent Aide, Therapeutic Child Care, Intensive Preservation, Family Violence Prevention, Early Childhood Development, Positive Youth Development, Parent Education and Assessment, Youth Parent, Substance Abusing Families at Risk, Care Coordination, Functional Family Therapy, Multi-Disciplinary Family Therapy, Drug Treatment, and Family Support programs are reported to DSS and a portion of these expenditures are claimed under the TANF program. In FFY '07, TANF claims for these services totaled $13 million.
- Under the BHP, IICAPS grant funds (that were partially charged to TANF) were converted into FFS payments that are authorized by the ASO and paid by the MMIS. DCF transferred funding to DSS to support the DSS payment of these services under Title XIX when they were provided to Medicaid recipients. DSS and DCF are currently considering a similar conversion for EDT. The FFY 2007 TANF claim for EDT was $6.7 million.

DCF ON A GIVEN DAY...

Often, DCF staff are asked about a typical day at the agency. Below are key numbers that depict DCF on any given day:

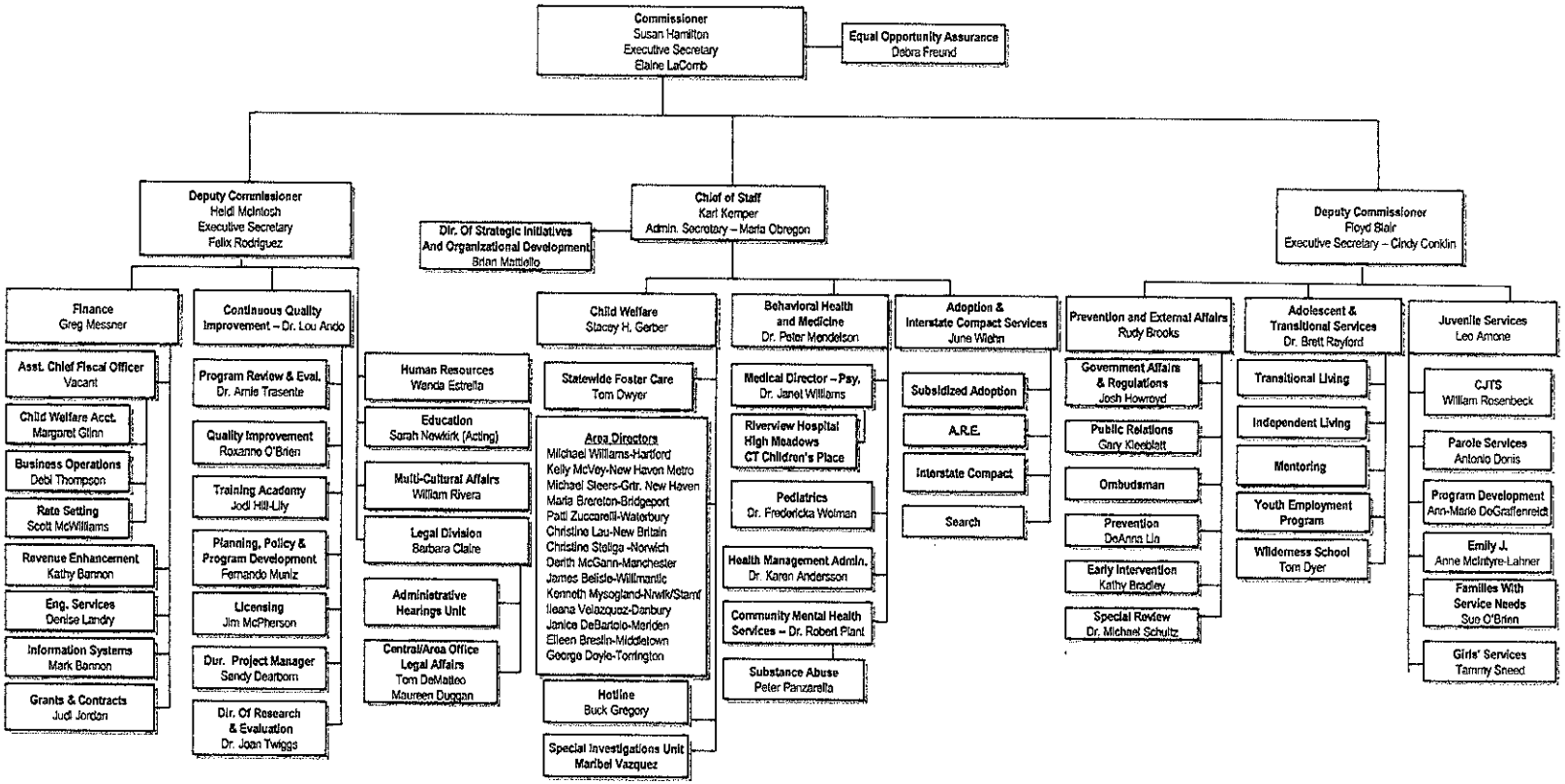
- Reports of abuse or neglect received 115-120
- Permanent homes found 2.3
- Children served Approx. 32,000
- Families served Approx. 16,000
- Children in Placement* Approx. 5,600

***Children In Placement Summary on October 1, 2008**

DCF FACILITIES	**174**
FAMILY FOSTER CARE	**2,679**
GROUP HOME	**428**
INDEPENDENT LIVING	**130**
MEDICAL OR HOSPITAL	**32**
PDC/SAFE HOME ASSESSMENT CENTERS	**151**
RELATIVE CARE	**915**
RESIDENTIAL TREATMENT CENTERS	**701**
STAR ASSESSMENT CENTERS	**76**
SPECIAL STUDY--FAMILY SETTINGS	**280**
TOTAL	**5,566**

CURRENT DCF ORGANIZATON

Department of Children & Families
Table of Organization
September2, 2008



MAJOR ORGANIZATIONAL DEVELOPMENT INITIATIVES

1) Strategic Planning and Organizational Changes under Consideration

The Department sought technical assistance from the National Resource Center on Organizational Improvement (NRCOI) in late 2007 to assist in the development of an integrated, agency-wide strategic plan. In February, the DCF Executive Team started the strategic planning process and has continued to further develop the details of this plan over the last several months.

The first step in this process was to define the outcomes and indicators by which the Department would assess its performance. While DCF has extensive experience managing by outcomes in the child welfare area, historically it has not identified and managed by measurable outcomes in other mandate areas to the same extent. And, equally importantly, the Department has not always been able to demonstrate that work across all of these mandate areas is integrated in a way that best promotes the achievement of a core set of agency-wide outcome measures and performance indicators. As a consolidated children's services agency, it is critical that the agency's strategic plan include these components and that it serves as a useful and integral management tool.

As of September 2008, the Department had developed a draft of the primary outcomes and the indicators that, in composite, will be used to assess performance. Work is underway to draw baseline measures from a variety of data sources that will be used to monitor these outcomes and indicators over time. In addition, the Department is finalizing a core set of action steps to promote these outcomes across all mandate areas, some of which are already underway. The Department has also developed primary areas of focus that will be included in the final plan, as well as sources of data and performance indicators that will continue to be collected and monitored by individual bureaus, divisions and facilities that will help to promote these outcomes and will serve as additional management and accountability tools.

A concurrent step during the development of the Department's strategic plan was to evaluate the effectiveness of its current organizational structure. During the course of this strategic planning process, it has become clear that changes to the DCF organizational structure are necessary in order to position the agency to accomplish its strategic planning goals. Re-organization is being considered solely as a means to support the accomplishment of strategic planning goals.

The reorganization involves the establishment of regional authority, including budgeting and resource management, as well as support staff from all bureaus being assigned to regional operations to ensure integration across all of our mandate areas. It will also involve integrating and combining several bureaus and local area offices and realigning resources. The expectation is to operationalize the final organizational changes by early next year. We do not anticipate that any statutory changes will be needed to effectuate these plans

As we proceed, the Department remains mindful of a finding in the most recent LPRIC study which was captured in the following excerpt from the report: "There was no evidence in 1999 (or now) linking effective service delivery to a particular organizational model (e.g. consolidated agency, an umbrella agency, coordinated independent agencies, etc.). According to national experts, what seems more important than any specific structure is: having clear policy to guide decisions on programs and services; ways to

systematically assess results; strategic planning to achieve measurable goals; and a strong management commitment to quality assurance and continuous improvement."

2) Results Based Accountability

DCF, along with other state agencies, is utilizing Results Based Accountability (RBA) for aspects of budget planning and oversight. Adopted by the CT State Legislature, RBA is a critical planning and policy tool used by the Appropriations Committee of the Connecticut General Assembly. RBA uses budget and performance baseline techniques to evaluate quality of life indicators and program performance measures, focusing attention on outcomes, not process. It provides an easy-to-understand approach to framing discussions about desired results.

RBA supports two primary levels of discussion: how the constellation of efforts across programs affects a particular quality of life result, and then, through the reporting of key performance measures for each program, how each program is performing for its customers. DCF submitted its budget information using RBA for new or expanded programs during the 2008 legislative session and for the Department's 2008-2009 agency/ program budget requests.

3) Data Reporting

The Department has several data reporting strategies for informing decision making and planning. The most significant of these include:

- LINK reports are available to DCF staff on line and offer an abundance of reports generated from client case records on topics such as child protective services reports, investigations, caseloads, children in placement, and permanency. Reports are prepared monthly and offer both statewide and area office specific information.

- Results Oriented Management (ROM) is a web-based management reporting system that uses client case record information captured in LINK. With ROM, managers can easily generate reports that capture performance around 13 Exit outcome measures and other indicators. Managers can customize reports for their own area office, supervisory unit or individual staff member.

- Risk Management data are submitted on a monthly basis by all programs, agencies or institutions currently licensed, contracted, funded or operated by the Department. Reports are generated on the number served and program accountability, as well as duration of physical restraints, non-serious and serious injuries, and other relevant information. This information is then used as part of the Department's licensing and program oversight responsibilities.

4) CT Behavioral Health Partnership (CTBHP)/Administrative Services Organization

The overarching aim of the CT BHP is to improve access to key services, more effectively allocate resources through enhanced care management, and improve the quality of care. Over the past year the Behavioral Health Partnership:

- Implemented an onsite review process with inpatient units, residential and psychiatric residential treatment facilities to foster improved treatment and discharge planning for children. The development of relationships with the units treating HUSKY children has resulted in a greater collaboration among treatment providers and improved treatment and discharge planning;
- Implemented the Provider Analysis and Reporting (PAR) Program by developing profiles (reports on utilization data) for inpatient child/adolescent hospitals in Connecticut and enhanced care clinics. Plans for the profiling of residential treatment centers in 2009, in collaboration with DCF, are already underway;
- Established a pay for performance program for inpatient child/adolescent hospitals in Connecticut. The methodology for this program was developed in collaboration with those facilities as well as with the Department. The goal of the program is to bring the length of stay at these facilities more in line with national experience and to decrease the amount of time children experience discharge delay. Similar programs will be established with other levels of care during 2009; and
- Established a quality of care monitoring program. Significant trends have been identified and quality improvement plans established. This work is increasingly integrated with the work of the Bureau of Quality Improvement within DCF.

The Department of Children and Families and the Department of Social Services have formed the Connecticut Behavioral Health Partnership (CT BHP) to plan and implement an integrated public behavioral health service system for children and families. The primary goal of the CT BHP is to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports and to improve member outcomes. Secondary goals include better management of state resources and increased federal financial participation in the funding of behavioral health services.

Value Options, the Administrative Services Organization, has the capability to track services received by children in the KidCare system of care and is able to generate over 200 reports, including length of time to answer the phone, length of time for providers to get questions answered, list of children residing in residential facilities, hospital discharge delays, daily census reports, and aggregate reports to identify trends.

5) Structured Decision (SDM)

Structured decision-making is an approach to child protective services that uses clearly defined and consistently applied decision-making criteria for screening for investigation, determining response priority, identifying immediate threatened harm, and estimating the risk of future abuse and neglect. Child and family needs and strengths are identified and considered in developing and monitoring progress toward a case plan. Structured decision making has been implemented in all DCF area offices and is intended to reduce the variability in decision making during the child protective services process.

In operation in over 35 child welfare jurisdictions, SDM is a statistically-valid and reliable, evidenced-based tool in child welfare. When fully implemented, SDM positively correlates with improving consistency in practice, reductions in recurrence of maltreatment, and reducing length of time to reunification.

Importantly, for front-line staff SDM emphasizes the importance of actively engaging the family to gather pertinent information that will enhance service provision to families and better meet their individual treatment needs. The SDM Family Strength and Needs

Assessment (FSNA) is a tool utilized by treatment workers designed to assess all family members on eight specific life domains. The tool helps identify strengths and priority needs for all family members (caregivers and children) that are subsequently incorporated into the treatment plan. The tool is required to be completed at 90 day intervals to reflect the changes in family functioning, progress and additional service needs for the family.

In July 2008, the Children's Research Center completed the case reading training on the FSNA statewide. The SDM coordinator will be offering additional case reading training sessions to supervisors/managers statewide relative to this tool to support successful implementation.

In September 2008, the Children's Research Center began conducting case reading training for treatment supervisors/managers on the SDM reunification assessment. This tool is used by treatment workers for children in out-of-home care with a permanency goal of reunification. The tool has four primary components: assesses family's risk level (evaluating family's progress towards treatment plan goals); visitation (assesses both the quantity and quality of parent/child visitation); safety; and permanency planning guidelines/recommendations for individual children placed in the Department's care. The tool is designed to expedite a safe return home or develop an alternative timely permanency goal should reunification not be feasible. This tool is completed at 90 day intervals. A training schedule has been developed for all area offices through March 2009.

6) Differential Response System (DRS)

Historically, the Department of Children and Families has followed a traditional child protective services model of investigation that was designed to gather facts that would result in a determination as to whether a child had been abused or neglected and by whom. The approach is supported by statute and language that speaks to: "allegations," "investigations," "substantiations," "victims," and "perpetrators." The gathering of facts to support a determination necessitates criminal background checks and collateral contacts and subjects, in most instances, the parent or guardian of a child to the risk of inclusion on the Central Registry as a perpetrator of child abuse

It is evident that the historical conduct of investigations is predicated on the principle of assuring the fundamental safety of a child. However, roughly 2 out of 3 investigations are initiated due to an allegation of neglect in families in which members frequently are struggling with domestic violence, substance abuse, mental health issues, low cognition, poverty or some combination of those factors. Accordingly, the issues of child and family well-being predominate in a system predicated on assuring safety. While the two are not mutually exclusive, critical in determining whether assistance is needed and the type of assistance that would best assist the family is information from the family about its own strengths, needs, history, hopes for the future of its members, and its commitment to the well-being of its members.

Differential Response shares principles with traditional investigation response by: (1) focusing on the safety and well-being of the child; (2) promoting permanency within the family whenever possible; (3) recognizing the authority of child protective services (CPS) to make decisions about removal, out-of-home placement and court involvement, when necessary; and (4) acknowledging that other community services may be more appropriate than CPS in some cases. Differential Response differs from traditional child protective investigations in that it (1) allows more flexibility in the response to child abuse and neglect reports; (2) recognizes that an adversarial

focus is neither needed nor helpful in all cases; (3) better understands the family issues that lie beneath maltreatment reports, and (4) engages parents more effectively to use services that address their specific needs.

The research supports the validity of a two-track system for initial contact with families following the receipt of reports of abuse or neglect. For a relatively small percentage of the cases that suggest acts of committed, emergent, or serious harm to a child; the traditional approach remains the "gold standard." However, for the majority of cases, evidence now supports Differential Response as an alternative that holds promise for increased engagement with families, greater client satisfaction, a more prompt access to services, reduced likelihood of families returning to the attention of child welfare, no increase in children being unsafe, and a decrease in the recurrence of child maltreatment.

DCF is engaged in full-scale model development and implementation of DRS and our current plans call for statewide implementation in SFY10.

MEASURING OUR PROGRESS

When considering this broad mission and the considerable resources dedicated to it, it is clear that the responsibilities of this single "child welfare agency" are enormous and complex. But it is important to remember that the work is done in partnership with a network of skilled individuals and institutions, which comprise the "child welfare system." It is important to see DCF as part of a larger network dedicated to protecting children and strengthening families. Measuring DCF's contribution towards this mission and assessing the agency's success in working with children and families must be important to all. DCF is continuously developing its means to evaluate performance, inform decision making, and provide an accurate picture for all stakeholders.

Below are highlights of some recent accomplishments/improvements.

- **Exit Plan Successes**--The Department is achieving or nearly achieving 20 of the 22 performance measures established in the plan to end federal court jurisdiction. For eight consecutive quarters the Department has met outright 16 or 17 of the measures, and fourteen of the goals have been met consecutively during the same two-year period. This consistent quality of work has brought the Department to a final phase where it is addressing the two remaining unmet outcomes.

- **Fewer Children In State Care, More Intact Families Served**--The number of children in care as the result of abuse or neglect has declined by 1,064 children or 16.7 percent since January 2004 and by 1,724 children or 24.6 percent since January 2000. This reflects a number of positive developments including a reduction in the number of children entering care and an accompanying increase in the number of families served with their children at home. Whereas 2,930 children entered care in 2002, the three-year average for 2005 through 2007 was 2,515.7, and the total for 2007 was 2,137. In-home cases have increased 41 percent from July 2002 when there were 2,849 in-home cases to September 2008 when there were 4,010 in-home cases.

➢ **More Out-of-Home Children in Family-Based Care**--Another important trend is that family care is growing as measured by the percentage of children first entering care being placed into a foster home, relative home or special study home. Whereas 57 percent of children first entering care were placed in a family setting in 2002, this has grown to 72 percent in both 2006 and 2007.

➢ **Meeting Goals For Timely Permanency**--Over the past eight quarters, all three measures of timely permanency, which include adoption, subsidized guardianship, and reunification, have met the goal in 20 of the 25 possible occasions. Timely adoptions, which represented just 10.7 percent of all adoptions in the first quarter of the Exit Plan, has been at or over 33 percent in each of the last seven quarters.

➢ **More Permanent Homes**--During state fiscal years 1997 to 2005, an average of 615 permanent homes (both adoptions and subsidized guardianships) were found annually for children in foster care -- more than four times the number in 1996. In FY2008, 634 adoptions were finalized and 234 subsidized guardianships granted for a total of 868 new permanent homes.

➢ **Provide Better Interventions To Assure Lower Levels of Repeat Victimization**--A critical indicator of the quality of services is the measure of children suffering repeat maltreatment (abuse or neglect). The percent of children who are victims of repeat maltreatment has fallen from 9.4% in the 3rd quarter of 2004 to 5.9 % in the 2nd quarter of 2008. The Department met the Exit Plan goal in the last five quarters and kept repeat maltreatment below 6 percent in the last three quarters.

➢ **Reducing Reliance on Residential Care**--The movement away from congregate settings for children in care is one that has been underway since the inception of the Exit Plan in 2004. The outcome measure for reducing reliance on residential care reached its best levels in the final two quarters of FY2008 and has met the goal for nine consecutive quarters. As of September, 2008, the number of children in residential care has declined by 340 children or more than 38 percent since April 2004. The number of children in residential care, 549 as of September, 2008, is at its lowest level on record. There are 160 fewer children (32.6%) in an out of state residential program: 491 in September 2004 compared to 331 in September 2008. Of those out-of-state, 74% are in New England.

➢ **In Home and Community Based Services**--The reduction in children in residential care overall is attributable to a number of factors. One clear improvement is that Connecticut now has the capacity to serve nearly 2,300 children a year in intensive home-based programs, which largely did not exist only a few years ago. Community based behavioral health funding totaled $69 Million in SFY 08 or more than double the amount spent in SFY 02 ($32 M).

➢ **Therapeutic Group Homes**--Another key initiative has been the development of new therapeutic group homes. These group homes provide intensive clinical services and allow children who would otherwise need a more institutional treatment setting to live in a home-like environment and attend school in the community. Since 2005, DCF has established 54 therapeutic group homes with a capacity to serve 273 children and adolescents. This initiative has been instrumental in enabling children to reside in home-like community based settings.

➢ **Post Secondary Education and Skill Building**--In the 2007-2000 academic year, DCF provided financial assistance to 671 youth for their participation (full or part time) in post secondary education, including technical school, two or four-year college, and

graduate school. That represents an increase of nearly 10 percent compared to the previous year. DCF continues its support until the youth reaches age 23. In FY 2008, over 1,036 service slots teaching independent and transitional living skills were offered to youths preparing to transition to adulthood. In particular, the Department provided 507 service slots to youth participating in the independent living and transitional programs. Components of these programs included housing, life skills instruction, and educational and training services (tutoring and, career and job exploration). The Department provided community-based life skills instruction to 248 youth residing in foster care. Youth were also provided with the opportunity to participate in one of the 246 contracted slots where they received job training, work and business development experiences, in addition to investment opportunities. Also, the Department offered additional opportunities to participate in a financial literacy and/or computer design class for 35 youth.

➢ **Juvenile Services Reforms**--A variety of new community-based services have been developed between 2005 through 2008 through the Emily J. Settlement Agreement, and expanded parole treatment services. Services include: gender-specific therapeutic group homes, specialized treatment foster care, in-home family therapy, increased flexible funding, and STEP school re-entry services, which have been established for delinquent girls and boys returning to their communities in Hartford, New Haven and Bridgeport. In addition, the Department is actively planning for and developing the services needed for the additional youth served by the Department when the jurisdictional age for juvenile court raises to age 18 effective January 1, 2010. These services include community-based services, residential and group home settings and an 18-bed, short-term secure facility for girls. All of the programs will provide gender-specific and informed programming.

➢ **Prevention Services**

Positive Youth Development/Strengthening Families

Six programs around the state (West Haven, Torrington, Enfield, Hartford, Willimantic and Bridgeport) focus on high-risk families with children age 6 to 15 to support parents in their role as parents. Based on local need, community providers under DCF contract have selected their program models from available evidence-based programs. Parents learn how to become more effective in their role and how to build stronger relationships with their children and stronger families overall. The Positive Youth Development Initiative (PYDI) served 221 families and 1,421 children under the age of 18 in the nine months ending March 31, 2007. PYDI began April 1, 2005.

Multi-media Public Awareness Campaign

To give families easy access to information and resources on a wide array of topics related to family health, safety, education and well-being, DCF has created a fun, interactive website (www.ctparenting.com). In June 2008, the Department deployed a statewide radio campaign to encourage families to visit this new website, while also reminding parents to keep their children safe in the water and near open windows during the summer season. The primary purpose of the website is to give parents ready access to a wide array of information to help them raise happy and healthy children. As part of this effort and in partnership with DEP, free swimming lessons were again offered to kids across the state.

Youth Suicide Prevention Advisory Board

Established through legislation, the Youth Suicide Prevention Advisory Board consists of members of public and private agencies as well as parents. Responsibilities include making recommendations, conducting awareness campaigns, and training. Over 1,000 DCF

social workers, parents, school staff, and community providers are trained annually. A media campaign and mini-grant project began in 2007. Collaboration with the Interagency Suicide Prevention Network and the Department of Mental Health and Addiction Services Youth Suicide Prevention Initiative has resulted in school projects across the state and training targeted to mental health experts, emergency personnel as well as the addition of a nationally-recognized training, ASSIST, to the repertoire of current training.

Parents with Cognitive Limitations Workgroup

The Parents with Cognitive Limitations Workgroup (PWCL) consists of several state agencies, service providers, and other stakeholders. The group works to develop a comprehensive, coordinated, efficient and effective system of policies, practices and services for families headed by a parent or other caregiver with cognitive limitations. Major accomplishments include the development of an assessment guide and a day-long training on identifying and working with parents with cognitive limitations (with CEUs for social workers). Over 500 DCF workers, other state workers and community providers throughout the State have been trained over the last 3 ½ years.

- **Early Childhood Program**

Early Childhood programs currently offered through the Department support the social and emotional health of families and children ages birth through six. These programs include the Early Childhood Consultation Partnership, the Parents in Partnership programs, and the Therapeutic Child Care programs.

The Early Childhood Consultation Partnership: It is estimated that 10 percent to 20 percent of the preschool population is in need of social or emotional support. In Connecticut, the number of children expelled or suspended from preschool has been alarming. The Early Childhood Consultation Partnership (ECCP) is a successful and nationally-recognized statewide program funded by the Department and managed by a private service provider. ECCP is one of the first statewide data-driven systems of mental health consultation designed specifically to meet the social and emotional needs of children from birth to five years of age by building the capacity of those caring for young children through the provision of on-site education and consultation in early care settings. Early childhood mental health consultants promote and facilitate early identification of young children's needs and respond with appropriate social and emotional services, community-based collaboration, and referrals to other service providers. The goal of the program is to enhance the development of social and emotional resiliency and to prevent children from disrupting from their early care settings. To date, ECCP has served 7,794 children were served in core classrooms with a 98% success rate in placement retention. The first year of the ECBC pilot indicated that 835 children were served with a record of no suspensions/expulsions.

The Early Childhood Parents in Partnership Programs (PIP): Implemented in the early 1990's, these programs have served close to 2,000 families identified as neglecting or abusing their children or to be at-risk of neglect or abuse. Participants have included parents with mental illness, parents with cognitive challenges, teen parents and substance abusing parents. Children are between the ages of birth and 6 years old. The Parent in Partnership model offers center-based playgroups, home visits, social activities and parent education as well as a link to community providers. Families participate for an average of 18 months and supports are provided several times a week through a combination of these options. After participating in the program, 96 percent of families are free of any referrals for abuse or neglect. PIP recently completed an RFP and selected two applicants to provide PIP in their communities. The

program has added a focus on Results Based Accountability and has added an evaluation component to aid in the future expansion of PIP.

Therapeutic Child Care Programs: Therapeutic Child Care Programs are offered to children between the ages of Birth through 8 years old. These children often experience significant social-emotional and behavioral challenges making it difficult for them to benefit from typical day care settings where there are many more children and fewer staff. Parents are often participating in mental health or substance abuse treatment programs. Services offered include bio-psychosocial assessment, development of comprehensive family treatment plan, a structured daily program of activities that promote gross motor and fine motor skills, language and literacy, early math and science, social skills and play skills. Therapeutic play is available for each child. Crisis counseling is available for adults and children as dictated by need. Services also include general advocacy and support for parents include parent support groups, educational advocacy, nursing services and community resourcing.

II. CONSENT DECREE OVERVIEW

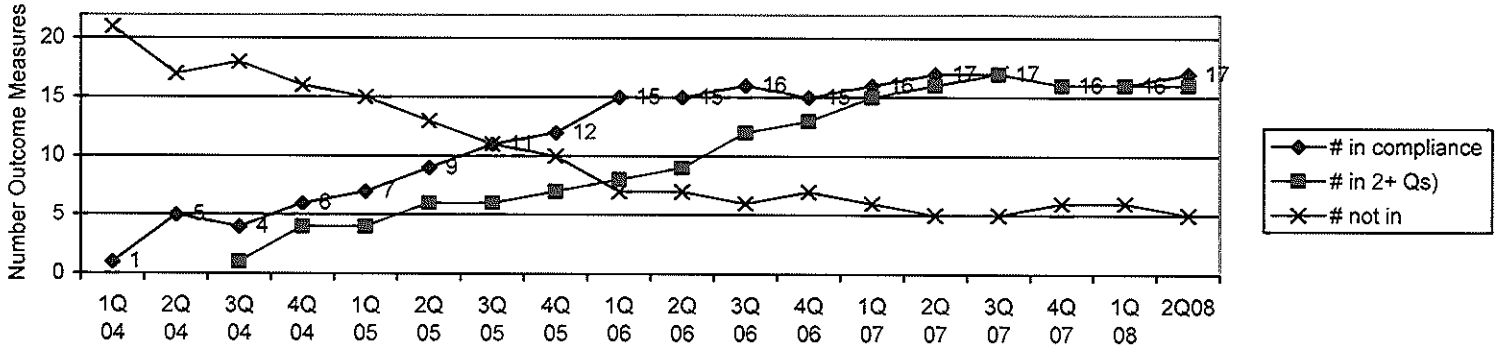
Background/Historical Context

In 1991, the State of Connecticut entered into an agreement with lawyers representing children in the *Juan F.* class to improve services provided by DCF. The agreement was filed as a Consent Decree order in the United States District Court of Connecticut. That agreement stayed in effect until 2002 when the parties established an initial plan to achieve exit from Federal Court jurisdiction. That plan, resulting from negotiations between the State of Connecticut and the plaintiff attorneys, set out 23 outcome measures, which, if met, would terminate the Federal Court jurisdiction in 2003.

In the Fall of 2003, after all parties, including the Court Monitor, agreed that the Exit Plan outcomes were not met, a new Exit Plan was established. In this plan, the Court Monitor took an active role in setting 22 Outcome Measures. The Department's success in meeting these measures has been rapid and substantial; six goals were met after the first year, 14 goals after two years, and 16 goals in the 4th Quarter of 2006. While the Department sustains these improvements, particular emphasis is now being placed on ensuring appropriate placements and timely permanency for children. A detailed action plan to achieve these critically important areas was established in March 2007 in a collaborative effort with Children's Rights, which continues to represent the plaintiffs.

Below is a summary chart of DCF's progress in meeting the 22 Exit Plan Outcome Measures since measurement began in 2004.

Figure VI-1. *Juan F.* Exit Plan Compliance Progress



To date, the Department is meeting or nearly meeting and sustaining its performance on 20 of the 22 measures. On May 5, 2008, the plaintiffs in the *Juan F.* case forwarded notification and assertion of non-compliance with Outcome Measure 3 (Treatment Plans) and Outcome Measure 15 (Meeting Children's Needs). A series of negotiations between the parties resulted in an agreement reached in July 2008. The Stipulation Regarding Outcome Measures 3 and 15 was approved and made an order of the Court by the Honorable Judge Alan H. Nevas on July 17, 2008.

THE EXIT PLAN MEASURES--DEFINITION

Outcome	Measure
OM1: Timeliness of Investigations	**90%** of all reports accepted commenced in stated timeframe
OM2: Completion of Investigations	**85%** of all accepted reports completed in 45 days of acceptance
OM3: Treatment Plans	**90%** of all cases shall have clinically appropriate plans developed in conjunction with parents, children, providers and others....within 60 days of case opening in treatment or placement date, and every six months thereafter
OM4: Search for Relatives	**85%** of all cases in which children are placed after January 1, 2004 must have document search
OM5: Repeat Maltreatment	**No more than 7%** of all children who are victims of a substantiated maltreatment shall experience additional maltreatment in the subsequent 6 months.
OM6: Maltreatment in Out of Home Care	**No more than 2%** of children in out of home care on or after Jan 1, 2004 shall be the victim of substantiated maltreatment by a substitute caregiver
OM7: Reunification	**60%** of all children reunified with parents/guardians shall be reunified within 12 months of their removal.
OM8: Adoption	**32%** of all children who are adoption shall be so within 24 months from date of removal
OM9: Transfer of Guardianship	**70%** of all children whose custody is legally transferred shall have such within 24 months of removal.
OM10: Sibling Placement	**95%** of siblings entering care on or after Jan 1, 2004 shall be maintained with siblings unless there are documented therapeutic reasons for separation.
OM11: Re-entry into Custody	**7% or fewer** of children entering care shall have had had prior out of home placement in 12 months preceding most recent entry.
OM12: Multiple Placements	**At least 85%** of children in DCF custody shall have no more than 3 placements during any 12-month period beginning January 1, 2004.
OM13: Foster Parent Training	**100%** of all foster parents shall be offered the opportunity to attend required training in the primary language of the foster parent, and in close proximity to foster parents.
OM14: Placement within Licensed Capacity	**At least 96%** of all children place in foster homes shall be in homes operating within licensed capacity
OM15: Children's Needs Met	**At Least 85%** of all families and children shall have all medical, dental, mental health, and other service needs met as specified on the most recently approved, clinically appropriate treatment plan
OM16: Worker-Child Visitation (OOH)	**At least 85%** of all children in out of home placement must be seen by an identified party **at least once a month. 100% must be seen quarterly by their DCF worker.**
OM17: Worker-Child Visitation (IH)	**At least 85%** of all active child participants living in the home with an open case, must be seen twice monthly.
OM18: Caseload Standards	**100%** of DCF staff shall not exceed caseload standard for greater than 30 days.
OM19: Residential Reduction	**No greater than 11%** of children in out of home care shall be in residential treatment.
OM20: Discharge Measure	**85%** of all children over the age of 18 and discharging from DCF custody shall have achieved one or more of the identified requirements.
OM21: Discharge of Mentally Ill or Mentally Retarded Citizens	**100%** of all clients requiring transfer to the adult systems shall have the required discharge plans submitted to DMR or DMHAS.
OM22: MDE's	**85%** of all children entering care for the first time shall have an MDE conducted within 30 days of placement

Juan F. Exit Plan Report Outcome Measure Overview
2Q 2008 (April 1, 2008 - June 30, 2008)

Measure		2004				2005				2006				2007				2008	
		1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q
1: Investigation Commencement	>=90%	X	X	X	91.2%	92.5%	95.1%	96.2%	96.1%	96.2%	96.4%	98.7%	95.5%	96.5%	97.1%	97.0%	97.4%	97.8%	97.5%
2: Investigation Completion	>=85%	64.2%	68.8%	83.5%	91.7%	92.6%	92.3%	93.1%	94.2%	94.2%	93.1%	94.2%	93.7%	93.0%	93.7%	94.2%	92.9%	91.5%	93.7%
3: Treatment Plans	>=90%	X	X	10%	17%	X	X	X	X	X	X	54%	41.1%	41.3%	30.3%	30%	51%	58.8%	55.8%
4: Search for Relatives*	>=85%	X	X	93%	82%	44.6%	49.2%	65.1%	89.6%	89.9%	93.9%	93.1%	91.4%	92%	93.8%	91.4%	93.6%	95.3%	95.8%
5: Repeat Maltreatment	<=7%	9.4%	8.9%	9.4%	8.9%	8.2%	8.5%	9.1%	7.4%	6.3%	7.0%	7.9%	7.9%	7.4%	6.3%	6.1%	5.4%	5.7%	5.9%
6: Maltreatment OOH Care	<=2%	0.5%	0.8%	0.9%	0.6%	0.8%	0.7%	0.8%	0.6%	0.4%	0.7%	0.7%	0.2%	0.2%	0.0%	0.3%	0.2%	0.2%	0.3%
7: Reunification*	>=60%	X	X	X	X	X	X	64.2%	61%	66.4%	64.4%	62.5%	61.3%	70.5%	67.9%	65.5%	58.0%	56.5%	59.4%
8: Adoption	>=32%	10.7%	11.1%	29.6%	16.7%	33%	25.2%	34.4%	30.7%	40.0%	36.9%	27%	33.6%	34.5%	40.6%	36.2%	35.5%	41.5%	33.0%
9: Transfer of Guardianship	>=70%	62.8%	52.4%	64.6%	63.3%	64.0%	72.8%	64.3%	72.4%	60.7%	63.1%	70.2%	76.4%	78%	88.0%	76.8%	80.8%	70.4%	70%
10: Sibling Placement*	>=95%	65%	53%	X	X	X	X	96%	94%	75%	77%	83%	85.5%	84.9%	79.1%	83.3%	85.2%	86.7%	86.8%
11: Re-Entry	<=7%	X	X	X	X	X	X	7.2%	7.6%	6.7%	7.5%	4.3%	8.2%	7.5%	8.5%	9.0%	7.8%	11.0%	6.7%
12: Multiple Placements	>=85%	X	95.8%	95.2%	95.5%	96.2%	95.7%	95.8%	96%	96.2%	96.6%	95.6%	95%	96.3%	96.0%	94.4%	92.7%	91.2%	96.3%
13: Foster Parent Training	100%	X	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
14: Placement Within Licensed Capacity	>=96%	88.3%	92%	93%	95.7%	97%	95.9%	94.8%	96.2%	95.2%	94.5%	96.7%	96.4%	96.8%	97.1%	96.9%	96.8%	96.4%	96.8%
15: Needs Met**	>=80%	53%	57%	53%	56%	X	X	X	X	X	X	62%	52.1%	45.3%	51.3%	64%	47.1%	58.8%	55.8%
16: Worker-Child Visitation (OOH)*	>=85% 100%	72% 87%	86% 98%	73% 93%	81% 91%	77.9% 93.3%	86.7% 95.7%	83.3% 92.8%	85.6% 93.1%	86.8% 93.1%	86.5% 90.9%	92.5% 91.5%	94.7% 99.0%	95.1% 99.1%	94.6% 98.7%	94.8% 98.7%	94.6% 98.5%	95.9% 99.1%	94.9% 98.7%
17: Worker-Child Visitation (IH)*	>=85%	39%	40%	46%	33%	71.2%	81.9%	78.3%	85.6%	86.2%	87.6%	85.7%	89.2%	89%	90.9%	89.4%	89.9%	90.8%	91.4%
18: Caseload Standards+	100%	73.1%	100%	100%	100%	100%	100%	99.8%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
19: Residential Reduction	<=11%	13.9%	14.3%	14.7%	13.9%	13.7%	12.6%	11.8%	11.6%	11.3%	10.8%	10.9%	11%	10.9%	11%	10.8%	10.9%	10.5%	10.4%
20: Discharge Measures	>=85%	74%	52%	93%	83%	X	X	95%	92%	85%	91%	100%	100%	98%	100%	95%	96%	92%	92%
21: Discharge to DMHAS and DMR	100%	43%	64%	56%	60%	X	X	78%	70%	95%	97%	100%	97%	90%	83%	95%	96%	97%	98%
22: MDE	>=85%	19%	24.5%	48.9%	44.7%	55.4%	52.1%	58.1%	72.1%	91.1%	89.9%	86%	94.2%	91.1%	96.8%	95.2%	96.4%	98.7%	93.6%

The Stipulation Regarding Outcome Measures 3 and 15

Below is a brief summary of the key components of the recent agreement reached with the *Juan F.* Plaintiffs to help improve performance related to Outcome Measures 3 (Treatment Plans) and 15 (Needs Met). Much of this information is taken directly from the Court Monitor's 2nd Quarter 2008 report filed on September 26, 2008.

Foster Care Recruitment and Retention Plans

On September 12, 2008, the Technical Advisory Committee (TAC) approved a Foster Care Recruitment and Retention Plan. The Plan is effective for the fiscal year July 1, 2008 - June 30, 2009 and for the fiscal year July 1, 2009 - June 30, 2010. The Plan was developed with internal and external input from stakeholders including the Court Monitor and the Plaintiffs' Counsel. The Plan includes both statewide and Area Office initiatives, as well as, recruitment and retention goals.

Service Needs Reviews

A heightened level of case reviews will be done for the following cohort groups to identify any unmet needs and to develop specific action plans to meet those needs.

1. All children age 12 and under placed in any non-family congregate care settings (excluding children in SAFE Homes for less than 60 days);

2. All children who have remained in any emergency or temporary facility, including STAR homes or SAFE homes, for more than 60 days;

3. All children on discharge delay for more than 30 days in any non-family congregate care setting, with the exception of in-patient psychiatric hospitalization;

4. All children on discharge delay for more than seven days that are placed in an inpatient psychiatric hospital; (21 children as of September 15, 2008)

5. All children with a permanency goal of Another Planned Permanent Living Arrangement ("APPLA");

6. All children with a permanency goal of adoption who have been in DCF custody longer than 12 months for whom a petition for termination of parental rights (TPR) for all parents has not been filed, and no compelling reason has been documented for not freeing the child for adoption;

7. All children with a permanency goal of adoption and for whom parental rights have been terminated (except those who are living in an adoptive home with no barrier to adoption and are on a path to finalization); and

8. All children with a permanency goal of reunification who have been in DCF custody longer than 12 months and have not been placed on a trial home reunification, or have not had an approved goal change.

Prospective Placement Restrictions

As of August 17, 2008, the provision of written approval by the DCF Commissioner, the Chief of Staff, or the Bureau Chief of Child Welfare commenced for all children given the goal of Another Planned Permanent Living Arrangement (APPLA). The Court Monitor will undertake a review of the Department's effort in this area as part of an overall review of each of the six Prospective Placement Restrictions (Section VI).

Health Care

A heightened level of review will be done to assure that children in care have timely Early Periodic Screening Diagnosis and Treatment (EPSDT) dental, medical, mental health, vision, hearing, and developmental screens and this will be provided with timely access to needed services identified by these screens.

Foster Care Recruitment

In particular, the recruitment of new foster homes has received considerable attention. The Department has developed an ambitious action plan that explicitly seeks to accomplish the following results over the next twelve months:

1. Achieve a net gain of 350 newly licensed foster homes on a statewide basis June 30, 2009. Accounting for anticipated home closures over this period, the Department is targeting 600 new homes (500 DCF Homes and 100 private Homes), with a particular emphasis in recruiting the following populations as a portion of these homes: 84 - medically complex; 90 - adolescents; 31 - African American; 60 - minority (other than African American), 119 - birth to age five; 96 - siblings; and 12 - gay/lesbian;
2. Assure that children and youths placed in foster care are in foster homes operating within their licensed capacity as measured by Outcome Measure 14;
3. Assure the appropriateness of a child or youth's placement and reduce delay discharges and overstays in temporary and congregate settings.
4. Increase foster parent satisfaction.

To place the net gain goal in perspective, the following chart depicts our baseline.

DCF Foster Homes (Point-in-time July 1, 2008)

Regular Foster Care License Type	Count of Providers	#Licensed Bed Capacity
Adoptive Care	283	478
Foster Care	1140	2410
Independent Foster Care	65	55
Relative Certification	1	2
Relative License	554	828
Special Study Foster Care	236	334
Total	2279	4107
Private Foster Care Licenses	1033	1085
Grand Total	**3312**	**5192**

The Department is proposing to recruit 600 new foster homes during SFY 2009. This reflects a distribution of 500 recruited by the Department with 100 secured by the Private Foster Care agencies. This data indicates that the Department recruitment goals for SFY 2009 and SFY 2010 will need to be ambitious and well resourced in order to obtain a net gain of 350 and 500 homes, respectively.

To accomplish these major goals, the Department's 2008-2009 Action Plan sets forth five statewide initiatives that are outlined in a comprehensive work plan that includes the strategies, next steps and assignments needed to achieve these initiatives. In addition, there is a comprehensive and detailed recruitment and retention plan for each area office. These area office plans set quarterly benchmarks for the recruitment of new family foster homes and describe in detail the goals, steps and persons responsible for each task. These local plans also identify primary and other community partners. The following is a summary of the five major initiatives the Department will undertake over the next twelve months:

1. Enhance Retention Efforts and Pre-Licensing Experiences for all Potential Foster Parents

The recruitment of new foster parents can be achieved most effectively by improving the support and retention of current foster families. Retention includes all pre-licensing work with those who are motivated to serve as foster families. Specific steps that will be taken include the following:

- The Department will improve the pre-licensing process to reduce the attrition rate of families who have already expressed interest in fostering, emphasizing more timely access to training and enhanced timeliness and support during licensure. This will be accomplished through resource and staff re-allocation, contract support and active area office use of a log of waiting families.

- The Department will improve its retention of current foster families using multiple internal strategies and through its contract work with the Connecticut Association of Foster and Adoptive Parents (CAFAP). Emphasis will be placed on improving the relationships between Department staff and foster parents, re-engineering workloads of support workers and providing foster parents with mechanisms for providing feedback to the Department.
- The Division of Foster Care Quality Management will conduct a study to determine if there are bottlenecks in the pre-licensing process and find ways to eliminate them.

2. Provide Foster Families Greater Access to Responsive Services, Training and Supports

The emotional, behavioral and medical problems of foster children placed in family-based settings have increased in recent years. Therefore, the supports and services to families must be related directly to the needs and acuity levels of these children and youths. Likewise, training programs for foster parents must be tailored to address these unique needs. Addressing these issues will help families to be more confident and capable in providing care, and support the stability of placements. Specific steps that will be taken include the following:

- The Department will identify and respond to foster parents' support needs through implementation of an annual needs assessment with foster parents, including surveys and forums. The Department also will use a Family Outreach Calendar, fully develop the Foster Care Family Advocate approach, maintain a Foster Parent Advisory Group, conduct staff training, update the Foster Parent Resource Manual, and offer outreach to the more than 55 foster care support groups statewide.
- Provide foster families greater access to behavioral health services and other supports through collaboration with the Behavioral Health Partnership.
- Redesign and enhance existing supports and services, including Therapeutic Foster Care, FAST, Safe Homes, and EMPS.
- Further develop the assessment and matching process.
- Provide greater financial incentives to foster families.
- Implement strategies to strengthen placement stability, including early intervention when a potential disruption is identified, development of a stabilization conference policy, allocation of $150,000 in flex funds for family-based support, and exploring with the Annie E. Casey Foundation the possibility of them providing technical assistance to DCF and implementing their team decision making model entitled "Family-to-Family."
- Continue to explore and implement post licensing training reforms such as collaboration with the state's community colleges.
- Office of Foster Care Services (OFCS) will conduct a study of under-utilized existing family foster homes.

3. Better Target and Inform Recruitment/Public Awareness Resources and Messaging

Good ideas and practices for recruitment exist in pockets, but our statewide approach to recruitment and public awareness can be coordinated and informed better to further develop existing ideas and practices. Specific steps that will be taken include the following:

- Establish an effective child-specific recruitment protocol with targeted populations and action steps.
- Create and sustain a statewide public media campaign.
- Establish and maintain local recruitment and retention plans.
- Better connect data to recruitment efforts.
- Continue to utilize foster parents in recruitment efforts.

- Continue to utilize adolescents in recruitment efforts.

4. Increase Timely Discharges from Congregate Settings

The Department is moving quickly to affect length of stays in congregate settings, including STARs, Safe Homes, Permanency Diagnostic Centers (PDCs), Private Residential Treatment Facilities (PRTFs), residential and group home settings. Specific steps that will be taken include the following:

- OFCS, in coordination with Area Office Foster Care, Child Protective Services staff, the BHP, and private providers, is engaging in targeted efforts to expedite the timely transition of children from these congregate care settings.
- Establish clear protocols for authorizations to Safe Homes/PDCs, with clear placement criteria and discharge planning expectations. Objectives include improving the management of referrals, the appropriateness of placement, the timeliness of discharge and accountability of the providers. The protocol will outline and clarify roles and responsibilities, timeframes for decision-making, and tracking and monitoring activities.
- Institute automatic case conferences for youths on overstay status in temporary settings consistent with the July, 2008 Stipulated Agreement under the *Juan F.* Exit Plan. The conferences will be held in the area offices and designated Central Office staff will be present. The review team will evaluate existing discharge plans, make adjustments if necessary, and identify additional supports and services to affect a successful discharge.
- Youths on discharge delay from residential settings and PRTFs will be assessed systemically to determine if they meet the criteria for family-based care and/or individualized services. Case planning will emphasize community-based options including a professional foster parent model and/or the provision of special incentives and supports for foster families.
- The Department will establish the Professional Foster Care (PFC) level of care. Currently, interim eligibility criteria are being established.
- Organizational enhancements will be implemented, including: increase the participation of Safe Homes and CPAs in local MSS processes; clarify the Therapeutic Foster Care Liaison role to help facilitate matches, transitions and discharges; and continue the development of practice and performance standards for all FASU positions.

5. Enhance Organizational and Workforce Development

Building the Department's readiness and internal capacity that is committed to foster family care and out-of-home care for children and youths is critical. Equally critical is building the capacity and readiness of our private foster care agencies and their families. We must enhance our partnerships with these providers, as well as better articulate agency expectations and clarify roles and responsibilities. Specific steps that will be taken include the following:

- DCF Workforce: continue toward specialization of the workforce; hold an annual foster care summit for key training activities; adjust staff performance standards as needed; revise the FASU portion of pre-service training; and set PARS goals and processes to be consistent with priorities outlined in this plan.
- Contractors: Improve provider communication and joint planning through bi-monthly statewide private provider meetings, bi-monthly Quality Improvement Teams for CPAs, individual provider meetings as needed, and systematic provider case reviews.
- Further develop and use LINK data management reports.

Taken as a whole, this plan is designed to better link committed families with a system of support and services and an infrastructure of training that is both sufficient and relevant. It aims to advance this important work consistent with the values and principles outlined herein. If executed properly, this plan will yield positive results, will be embraced by the dedicated staff at the Department and done in partnership with committed providers and advocates throughout the state. Most importantly, it will be done with the caring families that have come forward to provide foster care - effectively to serve as our most essential child welfare service for children and youth in out-of-home care.

More Detailed Look at Performance

As we implement the provisions of the Stipulation and further embrace the spirit behind Exit Plan Outcome Measures 3 and 15, it is important to gain the very best understanding of our performance on these two measures by looking beyond the single numerical finding reported each quarter. The Department has been perfectly clear that its performance on these two measures to date has met neither our practice standards nor the legal requirements under the Exit Plan. But in an effort to improve performance, the Department has found it necessary and important to take additional steps of analysis to better inform decision-making and permit the most accurate identification of any shortcomings or problems in practice. Recently, the Court Monitor adopted multiple views of the data gathered on these measures, and this has helped gain greater insights. (Note: below are several of these views. The source data is the Court Monitor's Office though some modifications have been made for the sake of presentation.)

By way of example, for the 2nd Quarter 2008, based on the Monitor's review of a 52 case sample, DCF attained the level of "Appropriate Treatment Plan" in 29 of the 52-case sample or **55.8%** and attained the designation of "Needs Met" in 29 of the 52 case sample or **55.8%**. In the past, these findings have prompted conclusions that the cases deemed not "appropriate" were not properly planned for or that nearly half the needs of children are not being met. Outlined below are four charts highlighting a deeper view of our performance on these two measures as reported by the Court Monitor's Office. They help place in a fuller context the strengths and challenges associated with our work in these critical areas of measurement.

1) **Outcome Measure 3**--This Outcome requires that 90 percent of the treatment plans reviewed must satisfactorily meet eight separate review criteria. Each criteria is evaluated on a 1-5 scale with scores of 4 or 5 being necessary to meet the standard. Although discretion is afforded to the Court Monitor to make scoring adjustments, the review methodology requires that all criteria meet this standard in order for the treatment plan to be deemed "appropriate." However, for example, because a treatment plan that is found "not appropriate" can have only one of the eight criteria ranked as "Marginal," it is useful to evaluate our performance in the aggregate, across all criteria.

The chart below depicts this view and demonstrates two useful points: 1) In the 52 cases reviewed, there were 416 total scores across the eight criteria (52 x 8 = 416). **Of these 81.25 % were given a passing score of either "Optimal" or "Very Good"; and 2) The categories where the Department has struggled the most, in this particular quarter and over time, has been in determining goals and objectives in the case and outlining the actions steps to achieve the goals identified.** This helps the Department focus its work in improving treatment planning.

Second Quarter 2008

Measurements of Treatment Plan OM 3 – Number and Percent of Rank Scores for Cases Across All Categories

Categories of Evaluation	Optimal "5"	Very Good "4"	Marginal "3"	Poor "2"	Adverse/ Absent "1"
I Reason for DCF Involvement	40	10	2	0	0
	76.9%	19.2%	3.8%	0.0%	0.0%
II. Identifying Information	9	42	1	0	0
	17.3%	80.8%	1.9%	0.0%	0.0%
III. Strengths/Needs/Other Issues	12	34	2	4	0
	23.1%	65.4%	3.8%	7.7%	0.0%
IV. Present Situation and Assessment to Date of Review	14	27	7	4	0
	26.9%	51.9%	13.5%	7.7%	0.0%
V. Determining the Goals/Objectives	13	20	15	4	0
	25.0%	38.5%	28.8%	7.7%	0.0%
VI. Progress	23	22	5	2	0
	44.2%	42.3%	9.6%	3.8%	0.0%
VII. Action Steps to Achieving Goals Identified	3	26	18	5	0
	5.8%	50.0%	34.6%	9.6%	0.0%
VIII. Planning for Permanency	25	18	9	0	0
	48.1%	34.6%	17.3%	0.0%	0.0%
Total Instances in which this Ranking was used	139	199	59	19	0

The Table below presents the mean averages and is provided as a way to show the trends with rankings across categories in Outcome Measure 3. Again, while the legal requirement under the Outcome Measure is for 90% of all cases to have an overall passing score rather than a statewide average within the passing range, this view demonstrates an important point: **Five of the eight categories had average scores at or above the rank of 4 ("Very Good") and the overall mean across all categories was 4.11.** Demonstrating our capacity to achieve the measure, seven criteria were scored at or above the rank of 4 ("Very Good") in the previous quarter.

Mean Scores for Categories within Treatment Planning Over Time
Outcome Measure 3 - Treatment Planning (3rd Quarter 2006 - 2nd Quarter 2008)

	3Q2006	4Q2006	1Q2007	2Q2007	3Q2007	4Q2007	1Q2008	2Q2008
Reason For Involvement	4.46	4.27	4.63	4.50	4.66	4.71	4.82	4.73
Identifying Information	3.94	3.89	3.96	3.82	3.92	4.16	4.18	4.15
Strengths, Needs, Other Issues	4.09	4.04	4.07	3.93	4.16	4.25	4.41	4.04
Present Situation And Assessment to Date of Review	4.14	3.97	3.96	3.93	4.02	4.29	4.45	3.98
Determining Goals/Objectives	3.80	3.48	3.68	3.66	3.70	3.82	4.00	3.91
Progress	4.00	3.91	3.87	3.86	3.82	4.31	4.35	4.27
Action Steps for Upcoming 6 Months	3.71	3.44	3.19	3.30	3.40	3.55	3.61	3.52
Planning for Permanency	4.03	4.04	4.13	4.01	4.08	4.24	4.43	4.31
OVERALL MEAN SCORE	**4.02**	**3.88**	**3.52**	**3.88**	**3.97**	**4.17**	**4.28**	**4.11**

2) **Outcome Measure 15 "Needs Met"**-This measure requires that 80 percent of the cases reviewed meet 100 percent of the needs identified across 11 separate review criteria. This Table demonstrate two useful points: 1) There is a marked difference in performance among the categories ranging from 57.7% for Mental Health, Behavioral and Substance Abuse Services to 98.1% for Legal Action. This allows the Department to focus actions in response to our performance based on this detailed level of evaluation; 2) **82.9% of "needs" identified across all cases reviewed, across all criteria (n= 458) met the standard.**

Treatment Plan Categories Achieving Passing Status for 2 Q 2008

Category	# Passing (Scores 4 or 5)	# Not Passing (Scores 3 or Less)
DCF Case Management – **Legal Action** to Achieve the Permanency Goal During the Prior Six Months (II.2)	51 98.1%	1 1.9%
Medical Needs (III.1)	50 96.2%	2 3.8%
Safety – In Home (I.1)	16 94.1%	1 5.9%
Safety – Children in Placement (I.2)	33 91.7%	3 8.3%
Dental Needs (III.2)	46 88.5%	6 11.5%
Educational Needs (IV. 2)	34 85.0%	6 15.0%
DCF Case Management – Recruitment for Placement Providers to achieve the Permanency Goal during the Prior Six Months (II.3)	29 82.8%	6 17.2%
Child's **Current Placement** (IV.1)	28 80.0%	7 20.0%
Securing the Permanent Placement – Action Plan for the Next Six Months (II.1)	28 77.8%	8 22.2%
DCF Case Management – Contracting or Providing Services to achieve the Permanency Goal during the Prior Six Months (II.4)	35 68.6%	16 31.4%
Mental Health, Behavioral and Substance Abuse Services (III.3)	30 57.7%	22 42.3%
TOTAL NUMBER OF "NEEDS" IDENTIFIED ACCORDING TO THEIR RANKING	**380** **82.9%**	**78** **17.1%**

From an alternate view, the data was analyzed to provide a comparative look at the median for each of the Outcome Measure 15 review criteria. As with the chart provided for Outcome Measure 3, this is presented as a method to identify trends across time, and is not a reflection of overall compliance with Outcome Measure 15. **Ten of the 11 review criteria had a mean score at or above a 4 ("Very Good" and meeting the standard) and the overall mean across all categories was 4.29 (out of a maximum of 5).**

Mean Averages for Outcome Measure 15 - Needs Met (3rd Quarter 2006 - 2nd Quarter 2008)

Outcome Measure Needs Met - Median Scores Over Time								
	3Q2006	4Q2006	1Q2007	2Q2007	3Q2007	4Q2007	1Q2008	2Q2008
Safety: In-Home	4.00	3.75	3.78	4.00	4.20	4.00	4.47	4.24
Safety: CIP	4.43	4.15	4.39	4.36	4.57	4.53	4.53	4.39
Permanency: Securing the Permanent Placement Action Plan for the Next Six Months	4.38	4.22	4.19	4.16	4.53	4.31	4.49	4.28
Permanency: DCF Case Mgmt - Legal Action to Achieve Permanency in Prior Six Months	4.29	4.45	4.67	4.67	4.74	4.65	4.74	4.81
Permanency: DCF Case Mgmt - Recruitment for Placement Providers to Achieve Permanency in Prior Six Months	4.42	4.42	4.20	4.43	4.56	4.47	4.65	4.46
Permanency: DCF Case Mgmt - Contracting or Providing Services to Achieve Permanency during Prior Six Months	4.17	4.03	3.79	4.13	4.12	3.98	4.29	3.96
Well-Being: Medical	4.31	4.34	4.28	4.22	4.34	4.25	4.49	4.69
Well-Being: Dental	4.47	3.93	3.87	4.13	4.12	4.25	4.29	4.40
Well-Being: Mental Health, Behavioral and Substance Abuse Services	4.40	4.07	3.72	3.91	4.02	3.88	4.00	3.65
Well-Being: Child's Current Placement	4.48	4.30	4.23	4.21	4.37	4.14	4.41	4.03
Well Being: Education	4.46	4.26	4.05	4.07	4.32	4.31	4.38	4.35
OVERALL MEAN SCORE	**4.39**	**4.17**	**4.15**	**4.21**	**4.35**	**4.25**	**4.41**	**4.29**

Taken together, the above data places the Department's performance in greater context. The data demonstrates better work overall on meeting children's needs and in the development of treatment plans and that the quality of work is not adequately presented when looking only at the percentage captured by the Exit Plan measure. Still, the Department has not yet met these measures and more work is needed. The Department is fully committed to making the improvements necessary to meet the outcomes as they are established under the Exit Plan and its methodology.

III. SPECIAL REVIEW: MICHAEL B. FOSTER CARE FATALITY

Background

On May 19, 2008, a 7-month old baby living in a licensed foster home died. State Police charged the foster mother, who was a DCF employee, in connection with the death, and criminal proceedings are ongoing. The baby, Michael, had been in the foster home for one week prior to his death, and his was the first DCF placement into this foster home.

The employee had worked at the Department since 1993. As is the case for every DCF employee prior to being hired, she was given a criminal background check as well as a background check for abuse and neglect. She had not previously been the subject of any disciplinary proceedings.

In February 2008, she was licensed as a foster parent by the DCF licensing staff using the same statutory and regulatory process and standards that apply to the licensing of all foster parents, which include a criminal and child abuse and neglect registry background check, a home study and assessment and a 10-week training program. She had also been licensed several years earlier by a private agency for an international adoption using the same strict criteria.

When the baby died, Commissioner Hamilton immediately commenced an investigation, including a review of the quality and thoroughness of the decision to license the foster home. The purpose of the investigation was to identify systemic or individual performance deficiencies that may have contributed to the tragedy so that they could be immediately addressed. While it is not possible to know whether having previously addressed the identified issues would have prevented the tragedy, the Department is committed to learning from past practice for the purpose of improving the quality of our work in the future.

During the course of this review, the Department found that the employee had two previous investigations in 2006 and 2007 alleging abuse of her own child whom she had previously adopted through an international adoption agency. Although the allegations were not substantiated, the quality of those investigations was substandard and unacceptable. Accordingly, it is unclear whether those allegations would have been substantiated if a more thorough investigation had been completed. And, because those allegations were not *substantiated*, the employee's name was not listed in the child abuse and neglect registry when licensing staff appropriately checked the registry as part of the standard licensing process.

Current Status

As a result of these findings, several actions were taken:

1) Licensing DCF employees: To avoid even the appearance of a conflict of interest, Commissioner Hamilton directed that DCF employees would no longer be licensed as foster parents by the Department. The Commissioner directed that effective October 1, 2008 a private agency would act as the licensing authority in the case of DCF employees. The Commissioner also directed that the Central Registry and all unsubstantiated employee investigations be reviewed for all employees who are *currently* licensed as foster parents to ensure that all relevant information was available at the time of licensure and that any corrective action be taken as needed. Both of these action steps have been completed.

2) Entering unsubstantiated investigations into the DCF database: Commissioner Hamilton directed that all investigations of DCF employees, substantiated or not, would be entered into the data base and that the decade-old practice of maintaining these in hard-copy only would be ceased. In addition, the Commissioner ordered that staff enter all prior unsubstantiated employee investigations into the database unless those investigations would now be expunged under state law and policy. Although it's impossible to determine whether in this matter the information of the unsubstantiated investigations would have changed the licensing decision, it's clear that it should have been easily accessible to the licensing staff. All prior employee investigations have now been entered into LINK.

3) Personnel actions and overhauling the investigations unit: Disciplinary actions were taken, including the termination of the accused employee and one investigator. Two managers were suspended without pay. In addition, the entire management team of the investigations unit in question has been permanently reassigned to other duties. The unit has been placed under new management and a complete overhaul of the unit has occurred including re-training of the entire staff on all relevant policies, practices and procedures. In addition, a review of all unsubstantiated investigations or substantiated investigations recommended for closure coming out of the unit was conducted to ensure appropriate quality.

4) Independent review by the CWLA: The Child Welfare League of America, along with the Department and the Office of Child Advocate, are conducting a comprehensive, independent review of this case to identify any other systemic areas needing improvement, and the Department will be prepared to follow up on any recommendations that come from that report when it is finalized.

For further information regarding this case, please see the attached response to the OCA **Attachment A**.

IV. DCF MONITORING AND EVALUATION

Background

In recent years, DCF has looked for new ways to assess its success with children and families based on reliable quantitative and qualitative data sources. The work of DCF is complex, and a sophisticated approach to planning, quality assurance and organizational development is essential. As a result, the Department has developed systems that gather and assess a range of information on quality and uses the information for planning, continuous quality improvement, and overall management efforts.

The agency's progress on this front was examined by the Legislative Program Review and Investigation Committee (LPRIC) in 2007. The purpose of their study was to determine areas of strength and weakness, as well as gaps and redundancies, in the existing DCF accountability system and to identify needed improvements. The study was premised on the fact that all monitoring and evaluation efforts - internal or external - are to ensure that programs and services are having the desired results.

The study identified departmental strengths, including: the *Juan F.* Exit plan process and related DCF area office quality improvement processes; the Department's licensing procedures; the agency's recently revised special review process; and the activities of on-site facility monitors. In addition, the study found areas needing work including: the agency's contracting process; the need to better utilize some important sources of feedback on services and programs; the focus of the Department's monitoring and evaluation efforts primarily on the child protective services mandate, due largely to the impact of the federal *Juan F.* lawsuit consent decree and requirements of federal agencies; and that there is a greater emphasis on tracking how services for children and families are delivered rather than on assessing their end results.

It is important to consider the significant growth and development the Department has undergone in recent years. The table below (from the PRI Report, December 2007) outlines developments related to DCF services since 1999.

In 1999	As of September 2008
Limited progress in complying with 1991 Juan F. consent decree	Exit plan with 22 specific outcomes approved and DCF implementing action plan to achieve compliance; as of July 2008, department met and sustained compliance with 16 measures for at least 2 consecutive quarters.
Neglect of children's behavioral health mandate	▪ Dedicated behavioral health bureau created in DCF ▪ Children's Behavioral Health Advisory Committee to the DCF State Advisory Council established ▪ Written agreements between DCF and DMHAS regarding transition services for children entering the adult system
Lack of comprehensive, integrated, community-based services	▪ Five DCF regions replaced with 14 service areas with intent of stronger local relationships and better service coordination. ▪ CT Community KidCare system (26 collaborative behavioral health service networks) in place statewide; KidCare system incorporated within Behavioral Health Partnership between DCF and DSS ▪ WR settlement agreement expands community-based services for children with complex behavioral health needs, with more collaboration among DCF, DMHAS, and DMR ▪ Emily J settlement increases community-based services for juveniles and collaboration between the courts (CSSD) and DCF

Juvenile justice population lacking appropriate services	▪ Emily J. settlement agreement provides more community-based wrap-around services to divert juveniles from detention ▪ Revisions to FWSN law include more community-based services for status offenders ▪ Reforms implemented at DCF secure facility for delinquent boys (CJTS) to improve assessment, treatment, and discharge planning
Lack of focus on prevention	▪ Children's Trust Fund resources expanded (to 18 staff and a current budget of $15 million) ▪ Small central office prevention division (3 staff) created and prevention liaisons assigned in area offices
Absence of national child welfare outcome standards for states	Federal Child and Family Services Review process established to measure states against national child welfare outcomes; DCF's second CFSR began September 22, 2008.
Modest attention to quality improvement	DCF Bureau of Quality Improvement created, area office quality improvement teams put in place, Administrative case review process implemented, automated "Results-Oriented Management" (ROM) information system established.
Fragmented complaint process for children, families and others	Independent DCF Ombudsman (with 8 staff) created to receive and resolve specific complaints "in a way that is in the best interest of children."
Inadequate automated information system and poor quality data	Improvement in the reliability of the central child welfare information system; management reporting capability (ROM) added that allows tracking of performance at all levels for key protective services functions.

The Department was in general agreement with the vast majority of the recommendations contained in the final LPRIC report. Below is a status update on implementation of those recommendations as well as other important initiatives in enhancing DCF's system of accountability.

Status of Major Areas of Recommendation from PRI Study:

Recommendation	Current Status
Use provider feedback re. procurement and program enhancement	On 7/16/08 the Contracts Director was assigned to take the lead to complete agency policy including standard notification and degree of involvement. Procurement schedule approved by OPM for Executive Team review. Notice and an opportunity for input into new program designs is now distributed in advance to a large list of stakeholder groups, including providers.
All DCF facilities to produce annual report for their advisory groups	▪ CJTS report will be produced in January, 2009. ▪ CCP, High Meadows and Riverview are establishing advisory groups, and their annual reports will be ready in January 2010.
Area Advisory Councils (AAC) to be invited to attend office Quality Improvement Team (QIT) meetings	This was not a viable recommendation given the variability of the AACs and the QIT process across area offices. Many have incorporated QIT into their management team structure. Of the 3 offices that invited their AACs to attend QIT meetings, none attended.
Strengthen State Advisory Council (SAC) with statute change for strategic plan oversight and provide SAC with	▪ The Director of the Policy and Planning Division continues to work with SAC. ▪ Consumer SAC members have been told that they can be established as vendors and reimbursed for travel.

administrative support and funding	▪ The Director of the Policy and Planning Division has provided information about the strategic planning process and explored options available regarding posting minutes. ▪ Statute change did not pass.
Establish electronic mechanism for SAC and AAC members to communicate	The Department will begin posting minutes without interactive component. SAC to take lead on the process.
Establish outcomes for each contract, collect data, compare provider performance, and take corrective action as necessary.	▪ The establishment of outcomes for all contracts and the time frame for accomplishment will be a part of the agency's strategic plan. ▪ The Department has worked closely with provider trade associations to develop core outcomes for all residential providers. ▪ Two meetings were held with Contracts and Fiscal representatives. Decision: to use performance indicators identified in the Logic Models as measures of performance.
Consider reallocation of Contracts Division staff	Agreed and decided it was not a viable option.
Require external evaluation of programs in excess of $20M	The Department will develop a protocol for determining the necessity of external evaluation that does not contain cost as a sole determiner.
Expand the role of the Service Enhancement Evaluation Committee (SEEC)	SEEC has been bi-furcated and other senior management meetings have been re-structured.
Establish repository for research and evaluation studies of the Department and its practices	Completed
Establish policy for responding to Special Review Unit (SRU) reports	Existing protocol is sufficient. The Bureau of Continuous Quality Improvement will do an annual statutes report of the results of the recommendations. Policy development underway.

Numerous internal quality improvement efforts, as well as oversight by multiple outside entities including federal and other state agencies, various advisory groups, the courts, and the legislature, have focused on how to achieve better outcomes for the children and families DCF serves. The 2002 federal CFSR identified DCF's quality assurance system as an area strength. Notably, the preliminary findings of the state's 2008 CFSR completed last week again identified DCF's quality assurance system overall as an area of strength.

DCF takes quality improvement seriously and has a Bureau of Continuous Quality Improvement (BCQI) dedicated to these functions. BCQI has five major areas of focus: internal quality improvement, workforce development, external quality improvement, planning and program development, and emergency response. While the majority of quality improvement functions are organized or conducted by this bureau, quality improvement activities can be found throughout the agency. Outlined below are some of the more significant activities:

1) Federal Monitoring and Evaluation

The focus of the federal Child and Family Service Review (CFSR) process is on a state's capacity to create positive outcomes for

children and families and on the results achieved by the provision of appropriate services. In this process, all 50 states, the District of Columbia, and the U.S. territories are assessed for substantial conformity with certain federal requirements for child protective, foster care, adoption, family preservation, family support, and independent living services. The Children's Bureau, part of the Department of Health and Human Services, administers this review system.

The purpose of the CFSR is to: (1) ensure conformity with federal child welfare requirements; (2) determine what is actually happening to children and families as they are engaged in child welfare services; and (3) assist states to enhance their capacity to help children and families achieve positive outcomes. Ultimately, the goal of the reviews is to help states improve child welfare services and achieve the below outcomes for families and children who receive services

States that do not achieve their required improvements sustain penalties as prescribed in the federal regulations. All 50 states, the District of Columbia, and Puerto Rico completed their first review by 2004. No state was found to be in substantial conformity in all of the seven outcome areas or seven systemic factors. Since that time, states have been implementing their Program Improvement Plans (PIP) to correct those outcome areas not found in substantial conformity.

Connecticut successfully exited its 2002 PIP on August 3, 2007. The second round of reviews began nationwide in the spring of 2007, and Connecticut's review was conducted in September 2008. Although formal findings will not be forwarded to the state until later this year or early next year, in an exit conference preliminary findings were shared with state officials and key stakeholders. Below is a summary of initial findings across 7 outcomes and 7 systemic factors evaluated through a comprehensive review of 65 cases (25 in-home and 40 out-of-home). The Department is interpreting these findings and anticipating the final report. A PIP will be entered shortly thereafter that will be consistent with our strategic planning goals and the action steps being taken in the final phase of the *Juan F.* Exit Plan.

OUTCOME MEASURES/FACTORS	PRELIMINARY FINDINGS	FEDERAL COMMENTS AT EXIT CONFERNECE
Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect. (This outcome includes items regarding the timeliness of initiating investigations of reports of child maltreatment and repeat maltreatment.)	100% of cases rated as "Substantially Achieved"	Believed to be the only state in the nation to achieve 100% on any outcome. Strength was shown in Department's response time with investigations and in preventing recurrence of maltreatment. It was also noted this accomplish is all the more significant given that Bridgeport, a large urban area, was one of the review sites. Many urban areas in particular struggle with this measure.
Well-Being Outcome 2: Children receive appropriate	95% of cases rated as "Substantially Achieved"	Ranked very high here not only for our work with school systems but as educators in DCF- run schools. DCF effectively works to

services to meet their educational needs.		identify educational issues and makes a good use of education consultants on staff.
Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.	85% of cases rated as "Substantially Achieved" with 93% for Out-of-Home cases and 73% for In-home cases	We are strong at assessing and providing services, and there was good engagement of families and high rates of "quality worker contact" (especially with children). It was noted that regular medical and dental care was provided and there is good reintegration work done following a detention stay, especially in linking youth and family to services. Weaknesses included engagement of fathers, not consistently taking a family-centered approach on Juvenile Justice cases and the need to better assess the needs of Foster Families. Also, it was noted we are good at identifying youth that need an adult system referral and good at engaging our sister agencies, but that the capacity limits and service gaps at these adult agencies are significant.
Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate. (This outcome includes items regarding services provided to families to protect child(ren) in the home and prevent removal and safety/risk assessment.)	80% of cases rated as "Substantially Achieved" with 83% for Out-of-Home cases and 76% for In-home cases	This was a measure we did not do all that well on in 2002--the last CFSR review. These are "strong" findings that favorably highlighted the timeliness of investigations, the functioning of our assessments and safety management, use of relatives at early stages of case, stringent use of background checks, service identification and coordination, and the effective implementation of Structured Decision Making. Concerns noted were that while client participation with services was strong, this access and participation did not always yield good outcomes. Fathers were often not assessed or addressed. Finally, parole and child welfare need a better way to coordinate interventions and improve communication.
Permanency Outcome 2: The continuity of family relationships and connections is preserved for children. (This outcome includes items regarding the proximity of foster care placement, placement with siblings,	50% of cases rated as "Substantially Achieved"	Sibling groups are not always placed together and, if separated, not always arranged to have visitation. Even though the state has achieved permanency in a more timely manner since 2002, the likelihood of achieving permanency for children with long stays in foster care remains low. Two of the three measured components of placement stability exceeded the national standard.

visitation with parents and siblings in foster care, preserving connections, relative placement and the relationship of child in care with parents.)		
Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.(This outcome includes items regarding needs and services of child, parents, foster parents, child and family involvement in case planning worker visits with child and worker visits with parent(s).	43% of cases rated as "Substantially Achieved" with 48% for Out-of-Home cases and 36% for In-home cases	Foster parents' and fathers' needs are not effectively assessed and addressed. Reviewers noted the achievement of outcomes on cases varied depending on the skill level of the social worker and the social work supervisor. However, they also noted the use of flex funds and the frequency and quality of visitation with children and their parents as strengths.
Permanency Outcome 1: Children have permanency and stability in their living situations. (This outcome includes items regarding foster care-re-entries, stability of foster care placement, permanency goal for child, reunification, guardianship, or permanent replacement with relatives, adoption and APPLA.)	31% of cases rated as "Substantially Achieved"	We rated the lowest here, along with most states. Strengths included low re-entry rates and use of relatives. Also, there was good support provided to foster families, but there needs to be a better way to assess needs of foster families and arrange services. Other weaknesses included use of APPLA, consideration of fathers as permanent resources, service outcomes, and legal delays--we are better at early stages of a case, but lack of timely filings and court delays increase as a case ages. These are areas we are already addressing.
Systemic Factors 1) Quality Assurance 2) Training of Staff and Foster/Adoptive Parents	Strength Strength	We effectively track trends and outcomes, and we examine through internal and external means our quality of services and practices. Our current mechanisms allow for extensive monitoring and review. CCOR (our internal case review modeled on the CFSR) was cited as a strength.

3) Agency Responsiveness to the Community	Strength	Significant public input into policies, practices, and services. It was noted there was a significant improvement in relationship with the Courts. Strong youth engagement and use of citizen advisory councils, cross agency communication and use of Managed Service System for provider engagement. With respect to innovations with older youth, we were recognized as being "national leaders".
4) Foster Care Licensing and Recruitment	Strength	
5) Statewide Information System	Concern	Related to the quality of our placement and legal status information
6) Case Review System (includes court hearings)	Concern	Administrative Case Review (ACR) process is solid, but follow-up from the ACR findings is weak and they found the process to be too compliance oriented--also participation varies and more should be done to accommodate parties. "Not being used to capacity".
7) Service Array	Concern	Service Array has great breadth and depth ("significant investment in children made in CT"), including prevention services. But can be confusing to workers and consumers regarding eligibility and purpose of services and the cohesiveness of the array and coordination of services. Also, the quality of some of the services in terms of achieving good outcomes for families was questioned.

2) State Monitoring and Evaluation

Over the past several years the Bureau of Continuous Quality Improvement (BCQI) has made significant changes both to the way in which it operates, and the way in which it is organized; during this time a large number of initiatives have been implemented. Some of these have been completed, and others remain in progress. These include, but are not limited to, the following:

- The Department's Quality Improvement Division collaborates each quarter with the Court Monitor's Office to review and assess cases statewide to determine the extent to which the agency is meeting its performance mandates in regard to treatment planning and needs met of children and families as outlined by the Juan F. Exit Plan. Areas of strength and those needing improvement are identified and utilized to improve agency practice and govern resource allocations in these key areas.
- Quality Improvement staff conducted case study reviews to evaluate specific child welfare outcomes as required by the Exit Plan.

- The Bureau established procedures for and implemented consultation and technical assistance to residential service and Therapeutic Group Home providers regarding compliance with the federal private non-medical institutions (PNMI) initiative.
- The Bureau is conducting monitoring reviews of all residential and therapeutic group home facilities to evaluate their compliance with PNMI regulations.
- The Program Review and Evaluation Unit has assumed responsibility for the Department's Credentialing of agencies and individuals providing services to DCF involved children and families in six specific service areas. The unit will also be assuming responsibility for the Department's Certification of Medicaid eligible in-home services which is scheduled for implementation in the fall of 2008.
- The Program Review and Evaluation Unit provides oversight for the initial approval and continued utilization of out-of-state residential facilities.
- Development efforts and activities continued to enhance the structure, action plans, learning forums, and goals of the quality improvement teams established in each area office and facility.
- The Department continued to meet the six-month periodic review of the status of each child/youth requirement through the Administrative Case Review (ACR) process. Strengthening of the program infrastructure was a critical focus, including: sustained efforts to ensure that the administrative reviews are open to the participation of both parents; initiation of the quality improvement aspect of the Administrative Case Review program resulting in the piloting and implementation of new procedures to further reinforce the review program; review and assessment of staffing needs toward building capacity; and the initiation of a training plan to concentrate on staff development in specific areas by quarter.
- The Department continues to collect and analyze restraint and seclusion data from both in-state and out-of-state providers. Comparisons will be made on frequencies of restraints and seclusions for all programs, in and out of state, that serve Connecticut children. Performance-based contracting data also is collected on in-state residential facilities.
- A quality improvement study was completed to examine the characteristics and factors related to families who are frequently engaged by the agency, in order to help improve agency practice and intervention strategies.
- In collaboration with other state agencies, the Bureau has enhanced and conducted regional training exercises with the statewide behavioral health response teams that provide disaster and trauma recovery to communities following critical events and emergencies resulting from natural disasters or from acts of terrorism. Training regarding disaster planning and response, including the FEMA mandated national incident management system, was offered and provided on a number of separate occasions.
- The Bureau has assisted in the planning and implementation of the ongoing restraint reduction plan for its child care facilities, including the collection and analysis of data to support this initiative.
- The Licensing Unit has begun the process of licensing four residential treatment facilities as Psychiatric Residential Treatment Facilities (PRTF). PRTF is a federal designation given to facilities that meet federal regulations regarding restraint and seclusion and treatment planning. In addition, revised regulations for the licensing of child caring facilities have been drafted and submitted for the legislative review process.
- The Risk Management Unit continued to receive, triage and coordinate responses to significant events that occur at congregate care settings in which our children are placed. Additionally, the unit tracks and monitors critical incidents and special

investigations. Unit management developed a new risk management logic model and a series of reports to facilitate more timely and appropriate responses to incidents.

- The Decision Support Unit (DSU) facilitated the adoption of an agency-wide logic model to articulate what outcomes the Department seeks from its private service providers. Members of the DSU continue to provide training and support to other DCF units regarding logic model implementation.
- The Training Academy strives to provide timely training programs that assist the DCF staff and community providers to respond effectively to children and families needing services. Through the implementation of a competency-based system, training programs and other initiatives relate specifically to the work tasks and ongoing development of DCF staff. Last year, the Department hired 173 new child welfare social workers who are required to complete 35 days of training spread over a period of a year. On-going training for experienced workers is also offered. An on-line catalog was developed last year to assists staff with efficient planning for attendance at training.
- In 2006, a comprehensive training plan for supervisors was developed by the Training Academy with assistance from The Child Welfare League of America and the Center for the Study of Social Policy. The training plan included a series of projects aimed at supporting supervisors in their critical role. These projects have played an instrumental role in advancing the skills and abilities of the supervisors.
- The Training Academy offers a variety of educational support programs and other workforce development programs designed to reinforce on-going educational and professional growth of DCF staff. These workforce development programs include the graduate education stipend program, the master of social work field education program, tuition reimbursement, the internship program, staff mentoring programs, and several post-masters certification programs.
- The Medical Review Unit implemented interpretive guidelines for therapeutic group homes in July 2007.
- The Medical Review Unit in collaboration with Risk Management implemented tracking and reporting of medication errors in all DCF licensed facilities in January 2008.
- In July 2008, Nursing Standards and Guidelines for all DCF licensed facilities were implemented.
- The licensing staff provides ongoing oversight of providers' compliance with licensing standards and assists in developing and implementing corrective action plans as needed.

In addition to the above work conducted by BCQI, "Program Leads" throughout other divisions are and one is identified for each service type for which the Department contracts. "Program Leads" are the primary contact for providers and monitor fiscal, program and model fidelity issues. "Program Leads" are provided Risk Management data and other information collected through the work of BCQI outlined above for consideration and action.

3) Connecticut Comprehensive Outcomes Review (CCOR)

Reflecting a commitment to the development of a comprehensive and meaningful review of statewide outcomes that can be used to further enhance case practice, the Department created its own case review tool called CCOR. The CCOR is modeled on the federal Child and Family Service Review (CFSR), which looks at the agency's performance across seven outcomes in the areas of safety, permanency and well-being. The CCOR, like the CFSR, is comprised of two phases:

1. Area Office Self Assessment - The area office completes a self-assessment document that describes their performance across the seven CFSR outcomes. This self-assessment is shared with the review team and serves to inform the reviewers of local strengths, areas needing improvement and practice issues identified by the local management team.

2. On-Site Review - A week-long case review is conducted by a team of reviewers on randomly selected cases. In addition to reviews of the case record and interviews with case participants conducted by reviewers, CCOR Team Leaders conduct focus groups with local stakeholders and providers to identify strengths and areas needed improvement.

Cases are randomly selected for review from the universe of eligible cases from the area office during a specific sampling period. Case ratings are determined from information gathered from the case record and interviews about the case practice during a specific period under review.

Each review team is comprised of five review pairs. Each review pair reviews two or three cases, including a review of the case record and interviews with key case participants. Review pairs use the federal On-Site Review Instrument (OSRI) to conduct their review. Completed OSRIs are submitted for quality assurance to the team leaders.

To date, the Department has reviewed a total of 47 cases in the Bridgeport, Manchester, New Britain and Norwich area offices using the CFSR methodology. CCOR reports have been issued on the findings of the reviews in Bridgeport and Manchester offices. Reports for the New Britain and Norwich area offices are pending.

4) Special Review Process

Finally, the Department of Children and Families, in conjunction with the Child Welfare League of America (CWLA), is providing comprehensive case analysis and timely systemic consultation in the aftermath of child fatalities and critical incidents. The case review, teaching and training involved in this effort are designed to generate practical feedback and information for professional learning, organizational development and staff support.

The Special Review process is designed to be distinct from employee investigations conducted by Human Resources (HR). If indicated, HR issues will be addressed soon after the fatality or critical incident becomes known to Commissioners and senior managers. Once the HR investigation is complete, one of the Special Review approaches may commence.

In conducting child fatality reviews the Department may partner with, in addition to CWLA, an internal DCF interdisciplinary team, area office and DCF facility review teams, the DCF Ombudsman, Division of Research, Special Investigations Unit, Program Review and Evaluation Unit, the Child Fatality Review Panel, and the Office of the Child Advocate.

V. RIVERVIEW HOSPITAL OVERVIEW

Background

Riverview Hospital is the only publically-operated psychiatric hospital for children in the state. The 88-bed facility treats children ranging in age from 5 to 18 years of age and has the clinical expertise to provide mental health treatment services for children who are experiencing extreme emotional and behavioral difficulties. Riverview Hospital serves an important role as the most intensive and restrictive psychiatric treatment setting within the behavioral health continuum of care developed by the Department.

Riverview Hospital offers in-patient services on eight units for children ages 5 to 18. Interdisciplinary teams consisting of a nurse, a social worker, rehabilitation therapist, psychologist, speech and language specialist, educational testing expert and child psychiatrist provide clinical evaluation and treatment. Riverview is accredited by the Joint Commission on Accreditation of Health Care Organizations. During FY2008, 236 children were served at Riverview Hospital.

In 2006, Riverview Hospital participated in a comprehensive program review resulting from incidents and issues at the hospital that raised concerns regarding the quality and effectiveness of the services and care provided to children. These incidents and issues were also sources of significant concern for the Office of the Child Advocate (OCA) and the Court Monitor's Office. Given their shared concerns, both offices actively participated with the Department in the program review of the hospital. A team of eight individuals representing the DCF Bureau of Quality Improvement, the Ombudsman's Office, the OCA, and the Court Monitor's Office conducted the program review as an ongoing collaboration that included weekly meetings to review activities and process findings.

The review findings were presented in a report, dated December 1, 2006, which outlined strengths, program challenges and recommendations for Riverview Hospital. Challenges and recommendations were outlined in the areas of management; communication; training; treatment discharge planning; the therapeutic model; population served; quality assurance; and physical plant.

As a result of these recommendations, the OCA's Supplementary Recommendations (December 11, 2007) and the findings from the David B. Report (March 27, 2006) was implemented at Riverview Hospital in June 2007 and will continue through June 2009. The monitoring process is a mechanism for ensuring that concerns and recommendations made in all three reports are adequately addressed. Observations made during the process are shared formally with the Riverview administration through Quarterly Reports.

Cost per Bed at Riverview Hospital

Treatment and care at Riverview hospital is expensive. There are different ways to calculate the costs. The Comptroller's estimate reflects a complicated calculation that takes into account centralized costs independent of Riverview as well as costs based on reconciling actual and estimated costs for unrelated time periods. Our own estimate of the annual cost per patient is approximately $700,000 for FY2008, with the overwhelming majority of expenses going to personnel services. In fact, about $27 million of the $34 million spent at Riverview in FY2008 was for personnel services. Workers compensation, which was as high as $2.8 million in FY2006, cost $2.2 million in FY2007 and $2.5 million in FY2008. An important reason why per capita costs have risen substantially -

- from $25.9 million in FY04 -- is that the census decreased more than 18 percent during the period. This reduction in census was approved by a report jointly issued by the Department and the Child Advocate.

This is a costly level of service. However, the children served at the hospital have the most intensive service needs that can be met no where else in Connecticut. Indeed, due to the intensity of their needs, children come to Riverview precisely because their needs were not met in other programs. Meeting these highest-level needs in a 24-hour, seven-day-a-week environment is costly. Comparing the costs at Riverview to programs that are unable to meet the needs of these particular children is not a like comparison. In addition, the Department is unaware of any other state-run psychiatric hospitals for children that can serve as a means for comparison..

The Department's estimate of annual cost per patient to operate the facility is approximately $700,000 for FY 2008, as calculated below:

	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Average Census	85.7	88.6	80.3	71.5	69.6
Total Days of Care	31,366	32,321	29,320	26,109	25,466
Personal Services	$21,576,500	$24,031,547	$24,726,915	$25,534,755	$27,647,357
Other Expenses	$2,526,671	$3,130,063	$3,680,426	$4,031,581	$4,141,966
Workers' Compensation	$1,792,289	$2,061,945	$2,770,764	$2,211,239	$2,478,652
Total DCF Cost	$25,895,460	$29,223,555	$31,178,105	$31,777,575	$34,267,975
DCF cost per day	$825.59	$904.17	$1,063.37	$1,217.11	$1,345.64
Annualized	$302,166	$330,021	$388,131	$444,246	$492,503
Fringe benefits (OSC)	$9,329,430	$11,720,531	$12,960,236	$13,724,302	$14,759,983
Grand Total Cost	$35,224,890	$40,944,086	$44,138,342	$45,501,877	$49,027,958
Total Cost per day	$1,123.03	$1,266.80	$1,505.40	$1,742.77	$1,925.23
Annualized	$411,028	$462,380	$549,471	$636,110	$704,635

The Comptroller's rate calculation is based on the costs from FY 2007, plus allocated statewide and DCF central office costs plus an inflation factor plus the difference between the estimated cost recovery from the previous year's rate calculation and the theoretical cost recovery based on the actual number of days of care in fiscal year 2007. Because the average census dropped about 10% between FY 2006 and FY 2007, the Comptroller's rate for 2007 was understated by nearly $7 million. This $7 million is then added to the costs which form the basis for the FY 2008 rate, even though this calculation has no relation to the cost of the facility in FY 2007 or FY 2008. It is probably important to note that this census reduction (which was endorsed in the report the Department issued jointly with the Child Advocate) therefore doubly inflates the Comptrollers rate, by both creating a difference between projected and actual cost

recovery for FY 2007 which increases the FY 2008 cost recovery projection, and by reducing the number of beds by which the total projected cost for FY 2008 is divided.

Thus, the Comptroller's rate calculation that results in an $864,000 cost for FY 2008 is as follows:

FY 2007 PS Cost: $25.5 million
FY 2007 Fringe Benefits: $13.7 million
FY 2007 OE Cost: $4.0 million
FY 2007 Education and Training: $0.2 million
Total FY 2007 Direct Costs: $43.5 million

Allocation of SWCAP & payroll costs: $1.5 million
Allocation of Central Office Costs: $7.2 million
Depreciation & Bond interest Costs: $0.8 million
Total FY 2007 Costs: $52.9 million

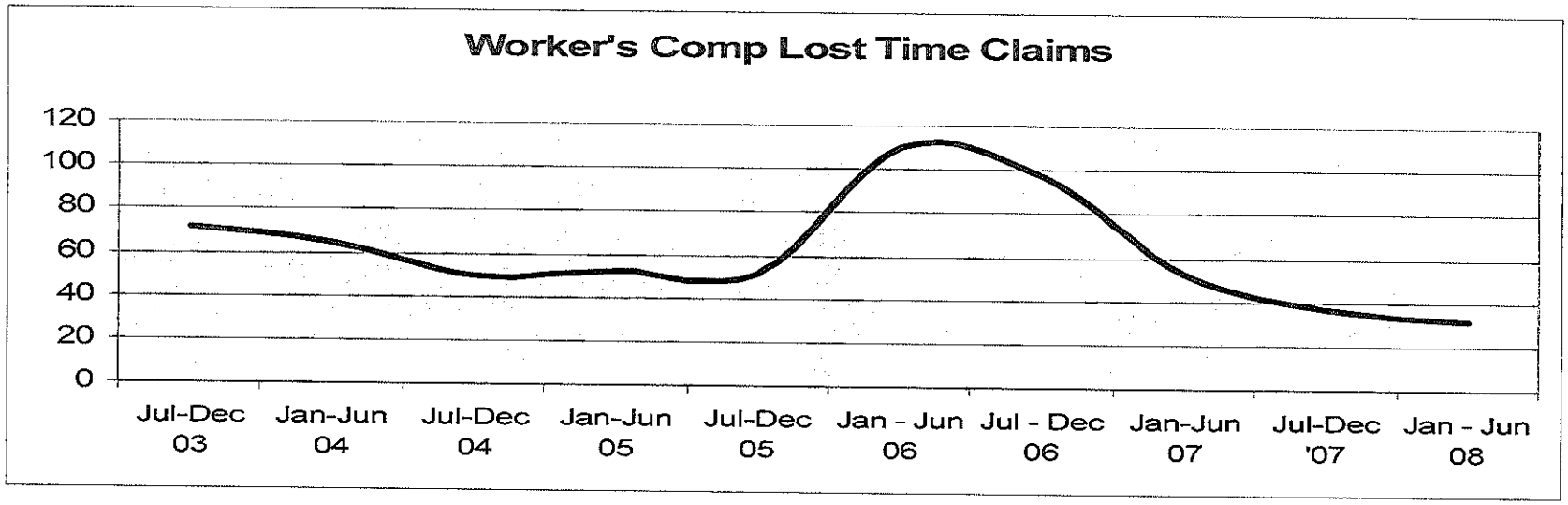
Rate calculated for FY 2007 from prior year's calculations: $1,983
Actual number of days for FY 2007: 26,109
FY 2007 rate times FY 2007 days: $51.8 million

Projected Cost Recovery for FY 2007 from prior year's calculations: $58.2 million
Difference between projected and actual cost recovery for FY 2007: $6.5 million

Difference between projected '07 cost ($51.8 million) and actual ($52.9 million): $1.1 million
Inflation from FY 2007 to FY 2008 (2.71% of $52.9 million): $1.4 million
Final cost basis for rate = $52.9 million + $6.5 million + $1.1 million + $1.4 million = $61.9 million
Projected days of care (OSC uses the prior year as the estimate): 26,109
$61.9 million / 26,109 days = $2,369 per day
$2,369 X 365 days = $864,585 per annum

Workers' Compensation--Change Over Time

The below chart tracks lost time due to workers' compensation. The trend demonstrates a sharp decline in claims for a two year period from mid 2006 to mid 2008.

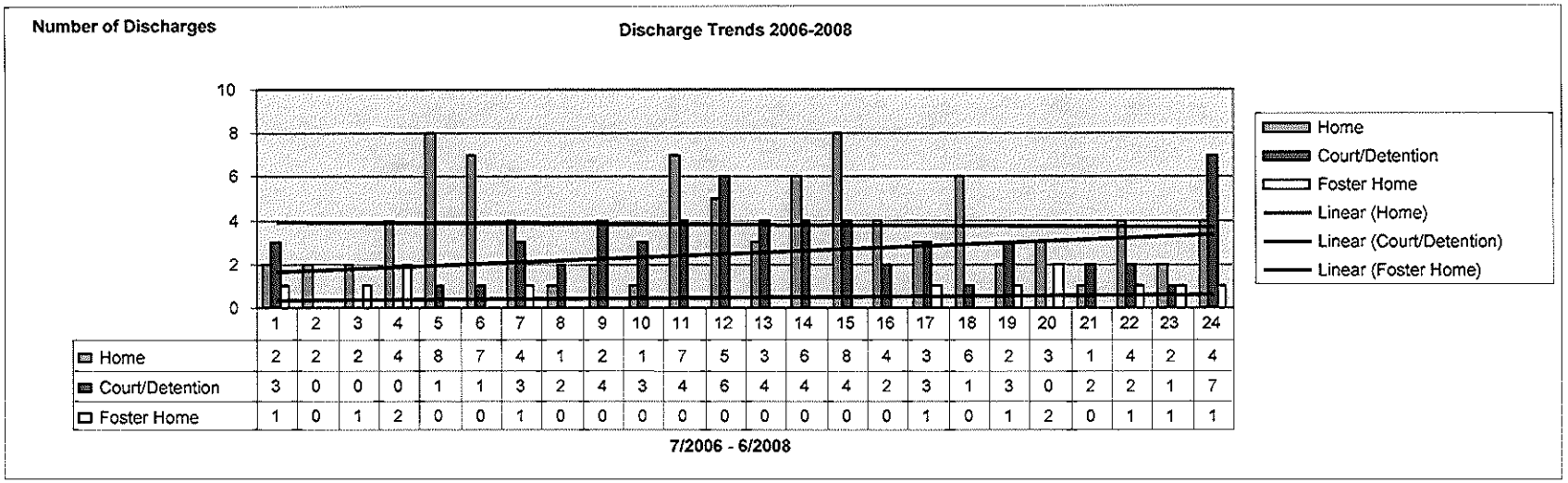


Admissions and Average Lengths of Stay--7/1/07 to 6/30/08

The chart below outlines the types of admissions and the range of legal status' of the children and youth receiving services at Riverview. For this 12 month cohort, the average length of stay is 154 days with 75 % of admissions involving DCF involved youth.

Total children admitted		**161**		overall average length of stay: 154 days
			% of Admissions	
DCF Involved				
	Committed	39	24%	
	OTC	11	7%	
	FWSN	10	6%	
	Open Case	7	4%	
	CPS In Home	23	14%	
	Voluntary	33	21%	
	Other/None (or none known)	38	24%	
		161		
Legal Status				
	Physicians Cert	37	23%	
	Court Ordered Evaluations	67	42%	
	Restoration	12	7%	
	Voluntary	39	24%	
	Unidentified	6	4%	
		161		

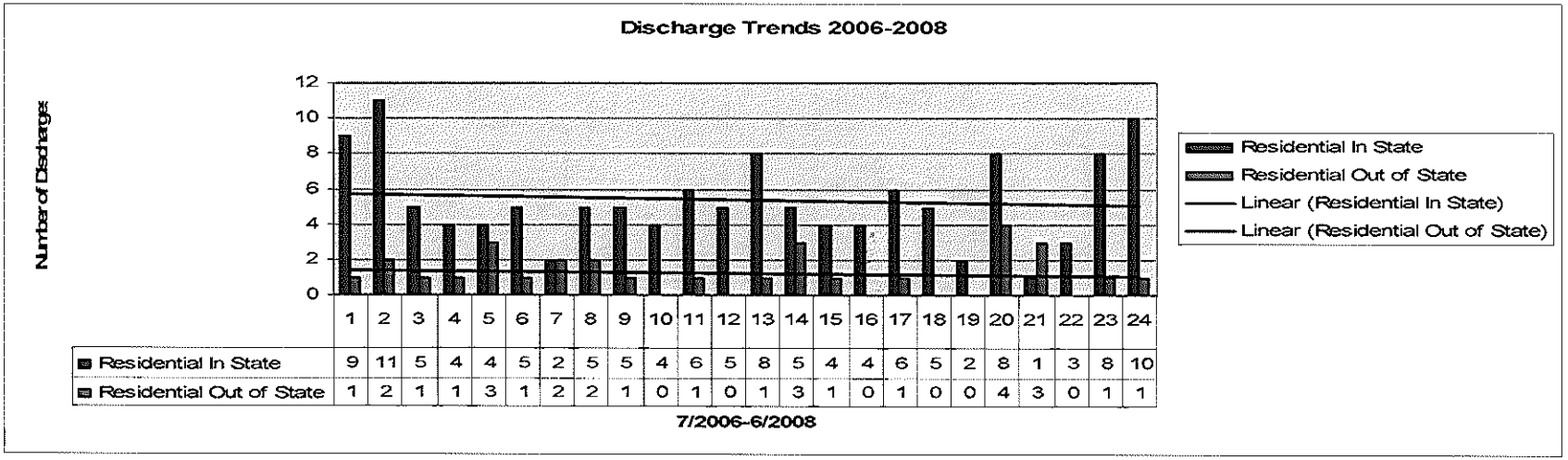
Discharge Trends--Family Based Settings



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Home	2	2	2	4	8	7	4	1	2	1	7	5	3	6	8	4	3	6	2	3	1	4	2	4
Court/Detention	3	0	0	0	1	1	3	2	4	3	4	6	4	4	4	2	3	1	3	0	2	2	1	7
Foster Home	1	0	1	2	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	2	0	1	1	1

*The trend lines should be read in relation to the bars. For home discharges you see a stable trend, for court or detention discharges you see a steady increase (many orders form courts for restorations and evaluations), and a slightly increasing trend for discharges to foster homes.

Discharge Trends--Residential



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Residential In State	9	11	5	4	4	5	2	5	5	4	6	5	8	5	4	4	6	5	2	8	1	3	8	10
Residential Out of State	1	2	1	1	3	1	2	2	1	0	1	0	1	3	1	0	1	0	0	4	3	0	1	1

Other Highlights and Important Considerations

Children treated by Riverview Hospital staff have the highest level of need of any in the state of Connecticut. They have extreme emotional and behavioral difficulties resulting from acute psychiatric disorders including schizophrenia, psychosis and bi-polarity that can give rise to self-injurious behavior. They exhibit the most challenging clinical presentations and behaviors, and this is evident by the criteria used to admit children to Riverview. In the Connecticut Behavioral Health Partnership's Child Psychiatric Level of Care Guidelines, which is used to determine a child's placement at Riverview, a patient must have a serious psychiatric disorder and co-occurring developmental disorder that require interventions not available in other inpatient settings. In addition, the patient must have a recent history of multiple admissions to acute inpatient settings over the past ninety days, and currently be receiving treatment in an acute inpatient setting with no appreciable improvement.

Among the challenges Riverview faces, maintaining a safe environment that supports effective treatment is most prominent. Riverview Hospital's strategic plan includes the goal of reducing restraints for very clear reasons. State law expressly allows the use of restraints when necessary where the child presents an immediate danger to himself or others. Given the fact that good practice would mandate that no child should be in a psychiatric hospital unless he or she is a danger to themselves or others, there will be occasions where the use of restraints is appropriate and necessary to provide safe care. There will be instances where the safety of a child and staff requires the use of restraints. However, restraints are related to injuries to both children and staff and any unnecessary or inappropriate restraints are to be avoided.

The Department acknowledges that recent trend lines for restraints and seclusions have increased, and we have been unable to provide a consistent downward trend over several quarters. However, there have been signs of progress. For example, Riverview has successfully eliminated the use of mechanical restraints on the West Campus, which include four units, including younger children units. Riverview also has been very successful in not using two-point restraints for the last 12 months, which also speaks to the hard work and dedication demonstrated by Riverview staff every day. Child injuries are decreasing as depicted below:

CHILD INJURIES	1/08	2/08	3/08	4/08	5/08	6/08	7/08	8/08	
01a Patient assaulted by another patient	5	5	2	1	2	4	5	0	24
09 Patient injured while acting out	7	7	7	4	5	5	2	1	38
09a Patient accidently injured, not while acting out	7	1	2	3	3	1	1	2	20

Over the past year, the Department and the OCA have jointly agreed on the many positive developments at Riverview, as outlined in the OCA's Quarterly Monitoring Reports. In particular, there have been intense efforts to communicate with and involve staff in all areas of improvements with a clear hospital wide goal to act on the need to reduce aggressive behavior in all of its forms (assaults, restraints and seclusions) and improve various treatment modalities.

More specifically, the first year goal of the Riverview Strategic Plan was to gather baseline data, to develop a comprehensive program plan to address staff development and to identify and implement training needs. The Strategic Plan was reviewed prior to implementation by the DCF Central Office, Court Monitor's Office and the Office of the Child Advocate as the response/plan of correction to the joint program review of 12/06.

In April, a process began to integrate the core strategies for Trauma Reduction in order to reduce restraints and seclusions. The projected timeline for conversion is by the end of this calendar year. The nationally recognized core strategies were formally made part of the hospital's existing strategic plan with specific action steps, timelines and outcome expectations.

The Hospital has made progress in providing a supportive supervision process that also ensures accountability to those in our care. This is evident in steps made to improve supervision processes and in the implementation of structures for accountability throughout the organization. In the area of supervision, a series of meetings have been established to provide supervision for programs, units and individuals. Most prominently, a Program Operations and the Hospital Leadership meeting was established at which leadership from all programs/units meet with members of the Hospital Executive Committee to establish the direction of the hospital in meeting pertinent strategic plan goals, reviewing progress toward those goals, and making adjustments when appropriate.

In addition, on a biweekly basis, unit supervisions occur involving the Program Manager and Director of Nursing for that area. They provide supervision to the Unit Psychiatrist, Nurse Manager and Behavioral Health Unit Supervisor of that unit. The following are a few of the items on the agenda for review: seclusion and restraint data; data related to incidents on the unit (e.g. patient or staff injuries, critical incidents, etc.); unit progress in meeting strategic plan goals; and consultation on supervisory issues and training/staff development needs. In addition, the Medical Director meets with all the psychiatrists individually on a weekly basis for individual supervision to discuss various clinical and programmatic issues.

On the units there are a number of established meeting forums aimed at both the supervision and support of staff who work within the milieu, either individually or in a group meeting. The group supervision processes occur in shift meetings, inter-shift meetings and supervisory staff meetings. Individual supervision in the Nursing Department is to occur at a minimum on a monthly basis. The Nursing Department has implemented a process to standardize supervision across the units through a format for strength-based individual supervision. Additionally, a co-supervision process has been piloted to coach new supervisors by pairing them with existing supervisors thus offering both support and guidance to the new supervisor. Depending on performance concerns, supervision may occur on more frequently than on a monthly basis.

The hospital units also have piloted different ways of offering clinical supervision to direct care staff. On two of the units, individual clinical supervisions have been offered to staff by experienced clinicians. On another unit, a group clinical supervision process run by the Nurse Manager and Behavioral Health Unit Supervisor was initiated to all the direct care staff working a particular shift.

Other related activities include:

- The Hospital Implementation Committee established a subgroup - Supervisory Training Development group - to develop a training curriculum for hospital supervisory staff. This group's membership expanded to include membership from other DCF facilities who have partnered in the development of a training model for facility- based supervisory staff. General content areas are: supervision of performance; basics for supervisors (self assessment, styles, etc.); building effective work teams; managing time; and delegating.
- In development is the offering of supervisory seminars on clinical supervision.
- The ABCD program (the hospital's milieu treatment program) has a component that utilizes a fidelity measure on how the unit is implementing the program as designed. By design, this fidelity tool also can be used to assess and give feedback on how individuals (at all levels of the organization) are doing in implementing and adhering to the programs' tenets. This feedback can be brought directly into individual supervision as performance feedback and to review goals for competency development.
- In developing staff competencies, the hospital has become a site for CMEs (physician continuing education credits) in collaboration with Connecticut Valley Hospital. Additionally, Riverview has recently been identified as a provider site for nursing continuing education credits.
- In moving towards evidence- based and best practices, all the psychiatrists participate in a monthly journal club which is open to all the DCF physicians. Monthly Grand Rounds at Riverview Hospital attract some of the National and internationally known speakers which contribute to increasing the knowledge of cutting edge clinical interventions and research in the area of mental health.

All hospitals, Riverview included, continually strive to integrate quality improvement throughout the organization. The Joint Commission, which has continually accredited Riverview, has extensive requirements for quality improvement efforts as they relate to practice, data collection and analysis. The OCA monitor has participated in many of the committees and functions that produce and discuss trended data. The monitor's participation and offering of her expertise has been welcomed and respected by members of the committees. While all standing committees have established performance improvement goals and measures of success with published quarterly reports, the review of the risk management areas are integrated into the daily operations of the hospital. There are multiple areas in which the noted risk management areas (e.g. restraint, seclusion, assaults, and injuries) are reviewed and discussed by all levels of staff at the hospital, including:

- Environment of Care meeting (monthly, reviews data on the five risk management areas)
- Nursing Leadership
- Medical Executive Committee
- Psychiatry Department meeting

- Program Operations weekly meetings
- Executive Committee weekly meetings
- Implementation Committee monthly meetings
- Unit Leadership Meetings

In addition, the systematic review of incidents occurs on-going as follows:

1) Incident reports are generated at the time of the incident.
2) Reports are reviewed by QA staff daily and separated as to level of severity.
3) Serious/Critical or repeated incidents are referred to the Director of Program Operations, Program Managers, Directors of Nursing, Medical Director, Superintendent and Assistant Superintendent, dependent on the nature of the incident.
4) Employee incidents regarding concerns of inappropriate work are referred to Human Resources in addition to the employee's overseeing Manager. Reviews of these incidents are conducted through a Clinical Review in which all individuals involved in the incident are brought together to discuss and recommend action to remedy or avoid repetition of the incident.
5) Unit reviews are conducted during inter-shift meetings and as needed on the unit by the program manager, unit nurse manager and Behavioral Health Unit Supervisor regarding patients, incident and intervention planning.
6) The Director of Program Operations and the Medical Director review every restraint review form.
7) The Program Managers conduct a restraint review on restraints occurring on their units. These are documented using a restraint review form and then discussed with the individuals involved in the restraint.
8) If any child requires two physical interventions in 12 hours or if an intervention lasts longer than four hours, the physician involved reviews the incident with the Medical Director during working hours and with the back up physician during after hours.
9) Finally, the hospital also conducts regular root cause analysis on significant events and Central Office, Special Investigation Unit conducts investigations of abuse/neglect and misconduct by staff.

The nursing department implemented on July 1, 2008 a new milieu progress note form. The intent of the form is to elicit a more qualitative note related to how the child is doing on their treatment plan within the milieu specifically related to their treatment goals. The original reception to this new format has been positive. Nursing leadership is presently initiating a re-education on expectations and developing a QA process to assess the quality of the notes from direct care. Also instituted was a format for acute note documentation. The **S** - situation, **I** - incident and **R** - response format helps to structure what needs to be objectively documented into a patient's record related to issues that arise that are not part of the milieu progress note (e.g. PRN efficacy, physical assessments, etc.

For further information regarding Riverview, please see the attached response to the OCA **Attachment B.**

VI. BEHAVIORAL HEALTH AND MEDICINE

Over the past several years, the Bureau of Behavioral Health and Medicine has made significant changes both to the way in which it operates and the way in which it is organized. During this time, a large number of initiatives have been implemented. Some have been completed and others remain in progress. These include:

1) The development of the Connecticut Behavioral Health Partnership and the implementation of an Administrative Services Organization and new data collection and reporting capacities;
2) A significant reduction in the number of children placed in residential treatment centers to comply with **Juan F** requirements;
3) A significant increase in the number of children referred to DMHAS and DMR;
4) The development of a statewide array of Foster Care Clinics with a corresponding increase in the timeliness of provision of multidisciplinary evaluations and screenings (medical, dental and behavioral health);
5) The elimination of shelters and their replacement with smaller clinically-informed, gender-specific, short-term assessment programs;
6) The development of over 50 new therapeutic group homes;
7) The development of a trauma-informed model of behavioral health care that informs the programs and systems used by DCF youth and implementation of a statewide initiative for Dialectical Behavior Therapy Training;
8) A dramatic decrease in the number of children on discharge delay from hospital emergency department s and inpatient units;
9) The development of a statewide system for medication tracking and permission processes (MEDMAC)'
10) The development of logic models for all behavioral health services funded or operated by DCF;
11) The development of a statewide medical services infrastructure with Regional Medical Directors, Regional Pediatricians, and a medical home model;
12) The development of improvements to behavioral health training components of the Training Academy program of pre-service training for DCF social workers
13) The development of an array of intensive in-home services
    a. Functional Family Therapy (FFT)
    b. Multi-Dimensional Family Therapy (MDFT)
    c. Multi-Systemic Therapy (MST)
    d. Family Based Recovery
    e. Multidimensional Family Therapy (MDFT)
14) The development of Family-Based Recovery (FBR);
    a. Collaborated with clinical researchers from Yale Child Study Center, Johns Hopkins University, and the University of Maryland to develop Family-Based Recovery (FBR), a new intensive home-based service that integrates adult substance abuse treatment with family treatment designed to enhance parenting and parent-child attachment. This service will be provided to infants (ages 0 – 24 months) who have been exposed to parental substance abuse in-utero and/or environmentally, their parent(s) and siblings. Providers will work in tandem

with DCF child protective services staff to promote the safety, permanence and well-being of children and families.

b. Developed RFP, evaluated proposals, and contracted with providers to add six FBR programs statewide, with a total annual capacity to serve approximately 72 infants and their families.

15) The development of Functional Family Therapy (FFT);

a. Developed RFP, evaluated proposals, and contracted with providers to add FFT services statewide. These new programs provide an additional annual service capacity for 265 youth and their families.

b. Collaborated with DCF Division of Juvenile Services to provide FFT services to children and youth involved with DCF Juvenile Services Parole. Expanded existing FFT program capacity and added FFT provider, resulting in increased annual statewide FFT capacity for 185 youth on Parole and their families.

16) The development of nursing care standards for children in DCF licensed facilities;

17) The certification of 214 medically complex foster homes;

18) The updating of the medically complex policy to better address the oversight requirements for staff serving a child with complex medical needs;

19) The implementation of a federal project called the Connecticut Adolescent Treatment Effectiveness Project managed by the DCF Substance Abuse Division This is a state incentive grant involving DCF, DMHAS, DOC, CSSD, DSS, SDE, and DPH and is designed to improve the quality of Connecticut's adolescent substance abuse treatment system and to integrate best practice models with child welfare and juvenile justice. Global Appraisal for Individual Needs (GAIN) has been implemented with DCF Social Workers with the Short Screen, the GAIN quick for in-home, and the GAIN with all outpatient and residential substance abuse programs;

20) The development and implementation of the CARES Program at Hartford Hospital to provide short-term treatment to youth in need of brief emergent care;

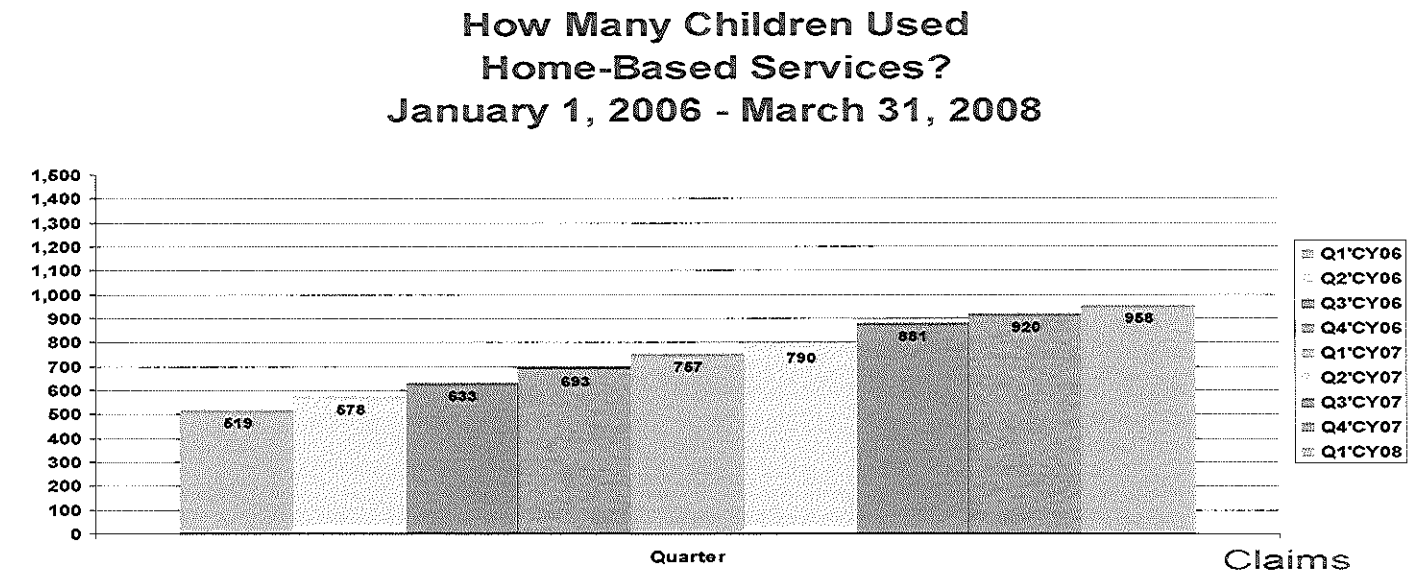
21) The successful transfer of the Voluntary Services Program for youth with developmental delays to DDS resulting in improved treatment and service for over 286 children;

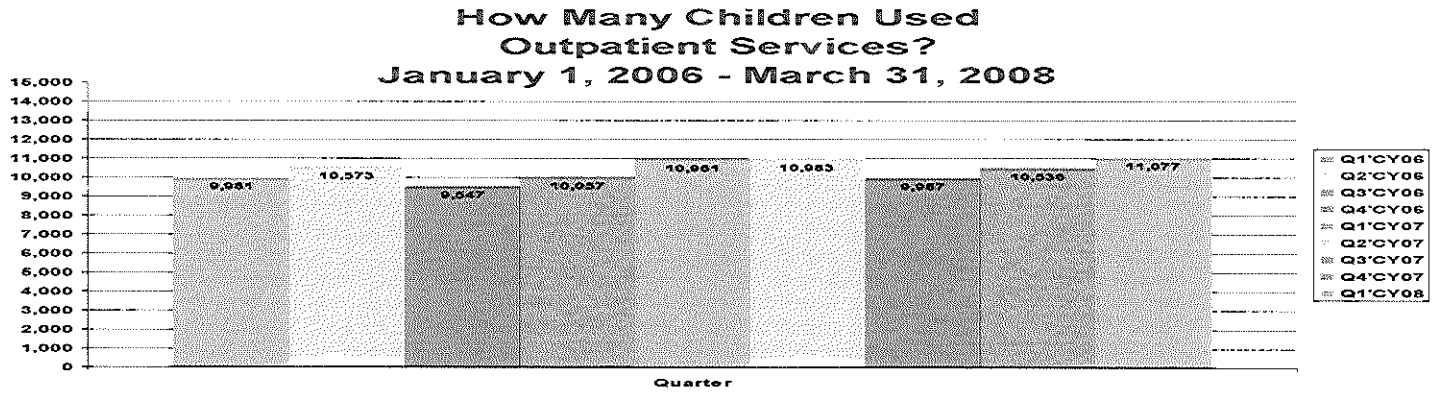
22) The redesign of our Emergency Mobile Psychiatric System to improve performance, mobility and outcomes;

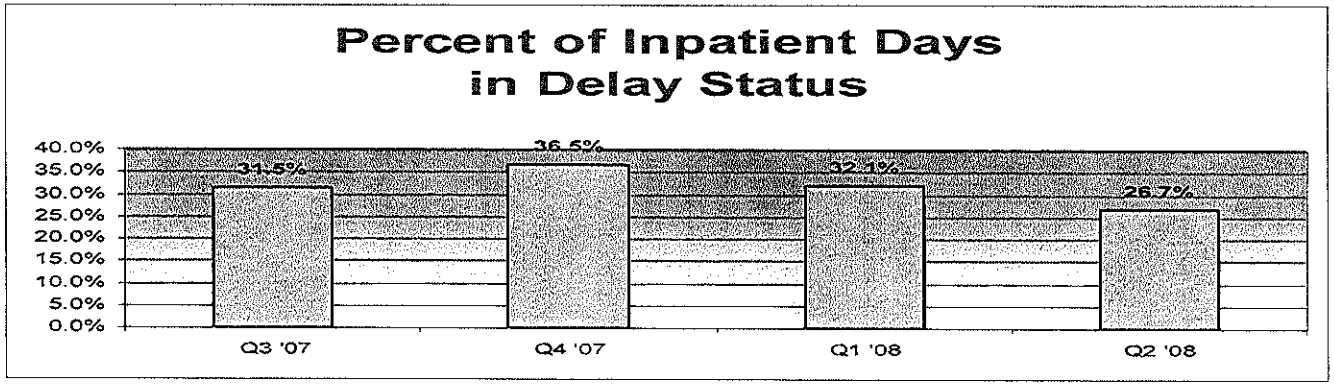
23) The development of two new specialized treatment centers (ABD and JRI) to treat special populations within Connecticut;

24) The development of a process for creating Individualized Service Proposals to assure that the needs of children with histories of mental illness and previous placement failures will be addressed.

Key behavioral health trends are depicted in the following charts:

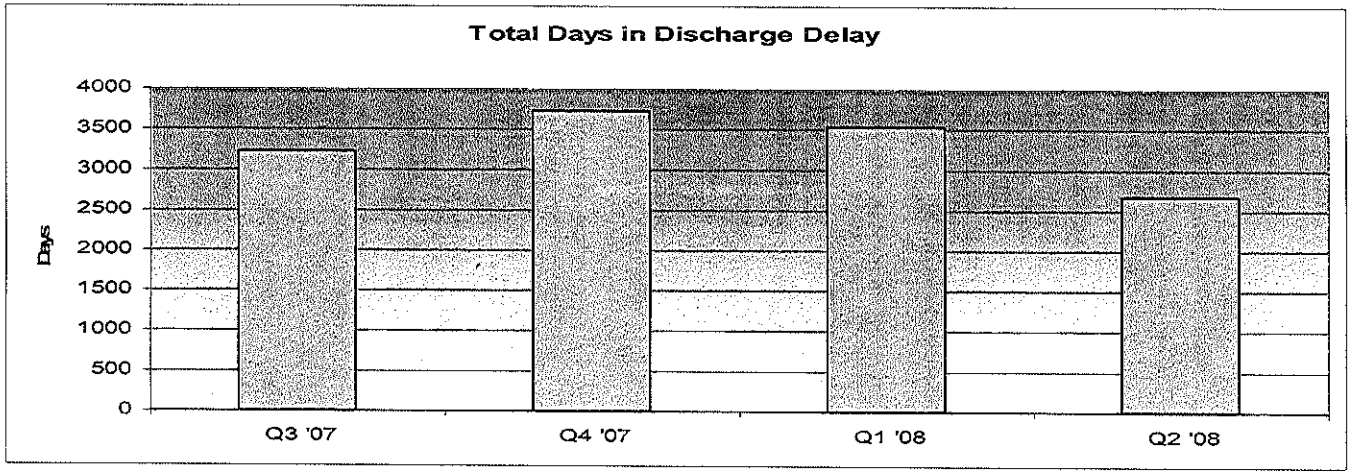






Includes: All cases discharged within the quarter or in care at the end of the quarter
Excludes: Riverview

Inpatient Days in Discharge Delay
All Children/Adolescents



TRAUMA-INFORMED AND GENDER-RESPONSIVE INITIATIVE

Considerable resources and attention are being given to implementing trauma-informed and gender-responsive service delivery model. This is affecting many programs and services, and, through this aggressive effort, the Department is realigning its approach to program development and service interventions. Given the importance and complexity of instituting these approaches, a phased implementation has been adopted as follows:

Phase 1 – Implementation of Trauma- Specific Services

- CJTS, Detention Centers, CCP and Riverview trained in Mants, Risking Connections and TARGET
- CCP, Riverview, CJTS and most DCF residential providers trained in DBT with year long consultation follow up and support.
- Ten outpatient clinics trained in TF-CBT with learning collaborative (web based).

Phase 2 – Implementation of Trauma-Informed Care (2005- continuing)

- 2005-07: Trauma-informed experts present often at CCP and Riverview
- 2006: Mandt Restraint and Seclusion training supports new thinking around working with traumatized clients
- 2006: Worker support groups are established for traumatized workers in several area offices.
- 2007: Domestic Violence Initiative and training begins within area offices.
- 2007: NASMHPD Trauma Informed education and assessment relating to restraint and seclusion as well as crisis response and debriefing are provided to RVH & CCP.
- 2008: Statewide Trauma Summit brings together experts to enhance our awareness.
- 2008 Risking Connection is being trained in Therapeutic Group Homes and STAR Homes.
- 2008 Implementation of a trauma screen (TESI and TCS) is required in 14 STAR Homes.
- 2008 Sanctuary Model trained at FCA

Presently underway.....

- 2008: Logic Model Formulated and Executive Committee established to oversee Logic Model
- 2008: NASHMPD training and strategic plan development for care collaboration and safety planning at RVH and CCP
- 2008: CCP and RHV self assessment of Trauma Informed Services
- 2008: Training Academy is actively implementing the training for pre-service workers on the new NCSTN child welfare trauma training toolkit.
- Behavioral Health Medical Team initiates quarterly Trauma Specific and Informed Trainings for all DCF area resource group and domestic violence staff.
- Selected Justice Resource Institute (JRI) to develop a trauma informed male and female residential program for developmentally delayed children..
- Domestic violence initiative contracted with seven domestic violence specialists for home-based service delivery. Carla Stover contracted to provide this new team TIGR education and consultations.
- 2008: A trauma informed group home for boys will open on the High Meadows campus in December.
- Began implementation of a trauma-informed debriefing protocol at High Meadows.
- 2008: DCF Statewide trauma consultations provided to social workers and special investigation units by Trauma Specialist.

GIRLS' SERVICES

The Department has continued progress with the development of Girls' Services. Program monitoring has included a comprehensive evaluation process with multi-bureau and multi-agency expertise. Preliminary results of the 18-month follow-up demonstrate significant improvement. The development of gender-specific residential guidelines, a DCF and CSSD collaboration, is in the final stages. The development of alternatives to residential care using models such as "Functional Family Therapy" and "Multi-Dimensional Treatment Foster Care" continue to reduce the number of girls in residential care. An ongoing focus is the development of group homes for girls committed delinquent and addressing the need for a secure program for a small number of delinquent girls.

- First program in the State designed for adolescent girls committed delinquent opened in December 1996. Touchstone opened as a 20-bed treatment facility, later expanding to 26-beds with 6 transitional beds.
- Connecticut Children's Place began serving girls on parole in 2000; Willow Cottage officially opening the day before Long Lane closed in 2001.
- Stepping Stone opened its doors on June 10, 2000 focused as step-down program for girls from Long Lane School. Stepping Stone worked collaboratively with Parole Services ensuring girls were prepared for a community based program with support from Long Lane School as needed.
- Long Lane School (female population) closed in 2001.
- Community Partners in Action (CPA) opened the Respite and Assessment Program (RAP) on September 1, 2003. RAP was a small, short-term assessment center located in Hartford specifically designed to assess girls entering the JJ system and transitioning girls to the most appropriate setting. RAP later closed in October of 2005; unable to manage the population. Journey House (July 30, 2004) and Stepping Stone's Expansion (spring 2005) developed as steps in a continuum to privatize this population. The day Long Lane closed, New England Center for Youth and Families opened a residential program for this population in Massachusetts (just over the border); also could not manage the population and eventually transitioned to serve primarily regional youth.
- The Plan for a Continuum of Community Based Services for Female Status Offenders and Delinquents was issued February 14, 2005 (2nd edition). This plan (commonly referred to as the "Girls' Plan") was a response to Substitute House Bill No. 5366, Special ACT No. 04-05.
- Early 2005 the Department hired the Director of Girls' Services for the Bureau of Juvenile Services.
- The Program Assessment project began in the summer of 2005. The goal of the project was to assess programs based on best-practices in the field of female-responsive programming. The project include a multi-agency, multi-bureau team working with a contracted provider in the development of an assessment tool and comprehensive program assessments of 3 of the privately operated residential programs (Journey House/ Natchaug, Stepping Stone and Touchstone). This was a 3-year project that resulted in valuable program information, recommendations and program enhancements.
- Later in 2005, DCF contracted with Dr. Marty Beyer to assess the State's needs in regards to the development of a state-operated secure program for girls. The report was issued on December 15, 2005.
- The Girls' Plan and Marty Beyer's Report both strongly recommend a system that is gender-responsive to females, providing a service continuum that meets the needs of every girl in the State. The reports emphasize the importance of ensuring girls have

healthy, positive and consistent relationships at every stage of her treatment. Quality improvement with state-wide training initiatives is highlighted as vital in both reports.

- Year 1 and Year 2 after the rollout of the Girls' Plan Juvenile Services offered a full array of training to the providers/ participants of the Girls' Network. Trainings included Trauma 101, Advanced Trauma, Gender Responsive Programming and Practices, VOICES, Girls Circle, Motivational Interviewing, etc.

Current Status--Important Considerations

- The Continuum of Care for adolescent girls committed delinquent includes residential treatment and a variety of community based services including Multi Systemic Therapy (MST), Functional Family Therapy (FFT), Support Team for Educational Progress (STEP), Outreach and Tracking (JCMC) and other service needs thru flex funding.
- Residential Programming is the highest level of care providing on-site education, treatment and recreation. Residential programs include Journey House, Stepping Stone and Touchstone with access to other residential programs within the State of Connecticut as well as minimal use of out-of -state providers. Journey House is the only "secure program" for girls in the State of Connecticut, operated by a private provider (Natchaug).
- Group Homes are the next level of care that includes 24-hour out of home support while education and treatment are transitioned/ provided for in the community. The development of two new 6-bed group homes for delinquent girls transitioning to the community is in process. Providers have been selected with current focus of siting and contract development. Funding delayed until January 2009.
- Development of an 18-secure bed program for girls committed delinquent with target completion of mid-2010. Plan to include additional 6-transitional beds. DCF meets with DPW every 2-weeks on this project.
- Program Guidelines for Girls' Services rolled out to the 3 residential programs; Journey House, Stepping Stone and Touchstone. Next step includes the development of a self-assessment instrument.
- Providers of the 3 residential programs meet on a monthly basis to discuss program development, share resources and system related issues. Eleanor House (Emily J Group Home) and the 2 new group homes will be included in these meetings.
- Re-design of a female-responsive parole system utilizing Court Support Services Division's model, adapted by Parole Services, to be completed by January 1, 2009.
- All programs within JS will be female-responsive; all will adopt the Program Guidelines for Girls' Services.
- All programs are/ will be trauma informed; TARGET and/or Risking Connections.
- Continuum of care will utilize Dialectical Behavioral Therapy (DBT).
- Continuum of care to provide the Ansell Casey Life Skills Program to all girls in the JS system; full training in November of this year.
- JS has begun process of meeting with the various police departments that cover areas in which our provider networks occupy.
- Contract language developed for the 2 new group homes that incorporate Program Guidelines Project definition of female-responsive programs should be included in all service types for the identified population. This definition was adopted by the Court Support Services Division as well. Definition:

Female-responsive programs intentionally incorporate research on female socialization, psychological, cognitive, and physical development, strengths, and risks to affect and guide ALL aspects of a program's design, processes, and services.

- Program Guidelines for Girls' Services is in the process of being adopted by all programs throughout the state of Connecticut. These guidelines will be incorporated into contract language.
- In addition to the Guidelines, programs to adopt the Ansell Casey Life Skills Curriculum across the continuum of services for girls.
- Bonding for the new secure facility was not passed by the Legislature until late 2007.
- York Correctional Institute: As of 10/14/08 there were 22 girls (under 18) at YCI. Of the 22 girls, only four were committed, and six were from families with an open DCF case.
- Program Evaluations done (3-year project) on Journey House, Stepping Stone and Touchstone. All three programs have taken the evaluations and have created program development plans/ activities. Journey House has made significant improvements and both Stepping Stone and Touchstone have approved program development plans.

DCF's ROLE AT YORK CORRECTIONAL INSTITUTE

Periodically concerns have been raised regarding girls who are incarcerated at the York Correctional Institution (YCI). Below are several facts and highlights of DCF's role and involvement with youth at YCI who are committed to or involved with the Department.

- As of October 14, 2008, there were 22 girls under the age of 18 at York Correctional Institute. Not all of these girls were involved with DCF. Six of the girls had an active DCF case. Four of these were committed and in the care of DCF. At the same time, DCF was also providing services to approximately 2,400 additional girls over the age of 15 either at home or in other community-based settings.

- Beginning the summer of 2006, DCF out posted a social work supervisor four days a week who advocates on behalf of the DCF involved girls at YCI as well as a social worker who splits time between YCI and Manson. These DCF staff work to identify and connect to services and supports from both DCF and DOC.

- DCF has assigned staff to attend weekly youthful offender meetings and schedule case conferences for DCF youth as needed. Also, a DCF manager has been assigned to provide oversight to the above staff, as well as attends weekly ASO rounds and participates in discharge planning. That manager also completes a summary for every DCF committed or voluntary youth and forwards to mental health staff at York.

- A memorandum of understanding between DCF and DOC was developed to more sharply define each agency's respective role involving DCF youth detained at or sentenced to YCI.

For further information regarding this Girls at York, please see the attached response to the OCA **Attachment C.**

DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Susan I. Hamilton, J.D., M.S.W.
Commissioner

M. Jodi Rell
Governor

October 2, 2008

Richard Blumenthal
Attorney General
55 Elm Street
Hartford, CT 06106

Jeanne Milstein
Child Advocate
999 Asylum Avenue
Hartford, CT 06106

Dear Attorney General Blumenthal and Ms. Milstein:

I am writing in response to your letter dated July 25, 2008 regarding what you view as a connection between a 2003 report you issued concerning the Department's investigations practice generally and the Department's specific response to the death of a child in foster care in May of this year. After careful review and consideration of your letter and the facts in this case, I respectfully disagree with your premise that this situation reflects the same systemic issues that concerned you in 2003.

As you know, I identified individual performance concerns regarding two investigations conducted by two staff members of our Special Investigations Unit (SIU) in the recent foster care case along with unacceptable performance by one manager. As discussed more fully below, this is not reflective of the quality of our investigations practice generally, which includes over 27,000 investigations per year statewide, and does not form a sufficient basis for drawing sweeping conclusions of systemic failures.

Along with the Department's response to those individual performance deficiencies, it should also be noted that the failure to enter DCF employee investigations into our statewide computer system (LINK) was limited to one unit and further limited to only those for whom a determination had been made that the individual did not pose an ongoing risk to children. However, as you also know, I found that practice to be inappropriate and took immediate steps to assure the inclusion of all past investigations of employees into LINK and to change that long-standing practice immediately.

Your 2003 report reflected your opinion regarding the performance of centralized intake and investigations as an entire functional area across all of our offices and used selected statistics as purported indicators of systemic flaws. More specifically, your 2003 report expressed concerns regarding our acceptance rate for abuse and neglect reports received

at our Hotline and utilized the National Child Abuse and Neglect Data System (NCANDS) as a source for your report. However, the NCANDS data on the rate of accepted reports per 1000 children in the population reflects that Connecticut has been more than 9% higher than the national average for the years since 2001. The comparison of substantiation rates is more complex given the variance across states in their statutory definitions of child abuse and neglect. However, to the extent that NCANDS data provides for apt comparison from 2003 through 2006, Connecticut exceeded the national rate for substantiation during that period for all but 2006, a year that Connecticut and the national average were virtually identical.

More importantly, the practice within Connecticut must also be viewed in the context of outcomes and prevailing standards, and the use of simple year to year statistics without context can easily present a misleading picture. In considering the quality of investigations practice, it is critical that outcome standards and evidence inform our collective conclusions regarding the safety and well-being of children. For example, as you may know, the recurrence of maltreatment is among the primary standards of assessing child safety in the field of child welfare. NCANDS trend data from 2005 notes an improvement in the recurrence of maltreatment rate in Connecticut from 2002 - 2005 of 28.8%. Our current recurrence of maltreatment rate of 5.9% is below the national median of 6.6%, is fully compliant with the *Juan F.* Exit Outcome standard negotiated with Children's Rights, Inc., and the consistent trend line of improvement is reflected in the sustained Exit Outcome performance on this outcome for the past 5 consecutive quarters.

In addition, as you may know, the federal Child and Family Services Review (CFSR) conducted every 5 years for all state child welfare systems across the country was just completed here in Connecticut last week. I am pleased to report that the preliminary findings gave Connecticut a rating of 100% in the area of safety, the highest safety rating that any state has achieved nationally. Moreover, two comprehensive case reviews conducted by the *Juan F.* Court Monitor's office since 2003 have concluded that our investigations were not only timely, but comprehensive and of high quality.

Your 2003 report also spoke to the frequency with which families come to the attention of the Department on multiple occasions but failed to note it as a national phenomena experienced by all child welfare agencies given the societal risk factors faced by many families in Connecticut and nationally. As you may know, over 70% of the investigations we conduct relate to allegations of neglect, rather than abuse, involving families who may be struggling to meet their children's basic needs for a variety of reasons. Eighty percent of our clients have incomes that qualify them for Medicaid benefits and their lives are often further complicated by substance abuse, domestic violence, mental health issues and cognitive limitations. Consistent with all other child welfare agencies across the country, the combination of these variables are so prevalent that the research in the field has coined the term "frequently encountered families" and has been instrumental in guiding practice change in child welfare.

Among the more promising practices to work with and support these families while ensuring child safety involves the use of a Differential Response System (DRS) being developed here in Connecticut and nationally, which provides a more assessment-

focused, strength-based and family-driven response to intervening with families upon acceptance of certain low-risk reports. The Office of the Child Advocate (OCA) was invited to participate in the planning for our implementation of DRS and has received documentation regarding the positive outcomes DRS has achieved nationally in reducing repeat maltreatment and reducing the number of "frequently encountered families" coming to the attention of child welfare agencies. We continue to welcome your participation as we plan for implementation of DRS targeted for July of 2009.

In addition, with regard to your global statements about quality assurance, it should be noted that the Department has continued to improve its reporting and analysis capability since 2003 and currently provides an array of data about its performance both internally and to our external partners, including, but not limited to, the *Juan F.* Plaintiffs and the OCA. Our child welfare managers have been trained in Microsoft Excel, and LINK reports are produced as pivot tables to readily afford local and meaningful analysis by our managers. Each area office has a Quality Improvement Program Supervisor with primary responsibility for data analysis, and we have established the Office of Research and Evaluation in the Bureau of Continuous Quality Improvement to utilize multiple data analysis tools, including Business Objects, the Statistical Program for Social Sciences (SPSS), and Results Oriented Management (ROM) through a contract with the University of Kansas. The bureaus of behavioral health and child welfare regularly utilize information produced by the Behavioral Health Partnership, and our Information Systems division regularly works with all functional areas of the Department to produce standard production reports reflecting the quantitative work of the Department. However, as quantity is but one portion of the picture, I have also instituted a well-regarded qualitative case review process that mirrors the federal CFSR in the domains of child safety, permanency and well-being.

The utilization of our data for quality improvement and quality assurance purposes is an effective management tool, has given rise to numerous practice and program improvements and continues to develop. In fact, although not recognized in your 2003 report or your recent letter, the 2002 federal CFSR identified our quality assurance system as an area of strength. Notably, the preliminary findings of the state's 2008 CFSR completed last week again identified our quality assurance system overall as an area of strength. I'd be happy to provide you with a copy of the final CFSR report once we receive it to assist you in understanding what national experts look at when evaluating this critical area of our work. It may provide you with a different and helpful perspective.

Your letter also makes reference to the importance of policy and regulation. I agree that it is important to memorialize standards of practice in policy. From the beginning of my tenure as Commissioner, policy development has been a standing agenda item of weekly Executive Team meetings. At those meetings, ideas regarding policy formulation are discussed among all Bureau Chiefs to assure that the implications and interactions among bureaus are fully understood and considered prior to approving any such policy. And, as in any organization, we make every effort to issue standard practice expectations to our staff through the issuance of formal policy rather than through informal communications to assure accountability.

With regard to your reference to communication within the Department, you should be aware that formal communication within the Department takes place in a variety of settings. A review of the most recent Legislative Program Review and Investigations Committee (LPRIC) report provides specific reference to our Service Enhancement and Evaluation Committee. In addition to the above noted Executive Team meetings, there are regularly scheduled statewide meetings of Area Directors, Behavioral Health Program Directors, Investigation Mangers, Quality Improvement Managers, Permanency Managers, Foster Care Managers and Adolescent Services Managers. Local management teams, supervisor meetings and quality improvement teams also serve as vehicles for the dissemination of information and regular statewide Senior Management meetings incorporate a much wider cross section, including bureau chiefs and division directors. The administration of the Policy Division through the Bureau of Continuous Quality Improvement reflects this administration's commitment to policy as an important vehicle to continued performance improvement.

In response to your question regarding documentation of investigative information in LINK, I indicated in my recent public remarks that a record of all individual employees having been investigated would be included in our automated system. This information would include the report and investigation protocol but not necessarily "all" investigative information since some of this documentation, including, but not limited to, original birth certificates, original Court documents, criminal background check results and correspondence, is received from third parties and is more appropriately maintained in hard-copy format. Each investigation has a standard protocol that reflects a narrative account of the investigator's activity, which, as noted above, is in LINK. There are additional aspects of our investigations that have not yet been automated but reflect the continued use of evidence-based practice. For example, within the last two years, the Department modified its domestic violence assessment using the results of the National Greenbook Project. In consultation with our statewide domestic violence consultant, we implemented a valid, reliable substance abuse assessment screen, the Global Appraisal of Independent Needs - Short Screen. Neither of the tools has yet been automated, but both are important investigation components that are part of the overall investigation assessment.

Also, as you know, I committed to the above noted data entry and the retraining of SIU staff in response to my review of the Michael B. case. Please be advised that both have been completed. The total volume of data entry was 549 employee investigations. Of those, 144 pertained to DCF employees in their capacity as parents or guardians, and the remainder pertained to our employees in their professional capacity. The Division of Human Resources (HR) receives notice at the time a report is received in which a DCF employee is alleged to have been the perpetrator of child abuse or neglect, and HR along with the responsible bureau chief receives copies of all investigations in which an employee has been substantiated as the perpetrator of abuse or neglect. The outcome of action by HR is determined on a case by case basis in compliance with prevalent state labor standards. As with any personnel investigation, discipline may be imposed, up to and including termination, if such action is warranted at the conclusion of the HR investigation.

The re-training of the SIU was completed on September 3rd and included all social workers and the supervisor of that unit. As all of the SIU investigators have prior experience as investigators, the training included a modified version of the curriculum offered by the DCF Training Academy for new investigators. I have attached a list of the specific trainings topics that were covered. In addition to the listed training, the unit has also received training in domestic violence assessment by our statewide domestic violence coordinator and very recently received training through Cornell University on assessing child abuse and neglect in institutional settings. As always, any ongoing training needs will be identified through ongoing supervision, review of case decisions by managers responsible for the SIU and through the use of other existing data reports.

The SIU was also trained in the use of Structured Decision Making (SDM) in 2006 and utilizes the safety and risk assessment tools for investigations pertaining to our employees in their capacity as parents or guardians. All managers statewide were also trained. Consultation occurred with the Children's Research Center (CRC), the developers of SDM, about the use of SDM in foster care and congregate care investigations, and it was determined that the tools were not valid for those purposes as the circumstances fell outside of the design parameters.

On a related note, I do not believe that the implementation of SDM should be characterized as DCF having "expended extraordinary resources." The contract with CRC was for 4 years and partially funded through federal grants. It is perhaps the most fundamental practice change within this state's child welfare system in decades and serves to address a principle concern of your 2003 report. With the advent of SDM, the decision to provide ongoing services to families is based on the risk of the occurrence of child maltreatment rather than upon an underlying substantiation. The tools are both valid and reliable, are supported by research, are in use in multiple states nationally, and the risk assessment tool specifically incorporates multiple contact with child welfare agencies as a component of the actuarial model of risk. We carefully chose to use a four year contract based upon our experience that a single episode of training was insufficient to bring about true systemic implementation given the scope of the change. At this time, CRC is assisting with the case readings for quality assurance purposes and continue to assist us in identifying implementation barriers. The final phase of the contract calls for a modification of the tools to reflect outcomes from data derived exclusively from Connecticut. Given that SDM touches the nearly 30,000 reports and associated child welfare follow-up with the families coming into contact with this agency each year, the four year impact will exceed 100,000 families. The total SDM contract cost is both reasonable and responsible given its scope and resulting improvement in child outcomes. In fact, I'm proud to note that we have been invited to present at the national SDM conference this year as a model for the statewide implementation of SDM.

You have also asked about the status of our Foster Care plan. I have included the DCF Family Foster Care Action Plan for your review, which was recently approved by the Center for the Study of Social Policy in consultation with the Department as part of our recent agreement with the Plaintiffs in the *Juan F.* case. If you have any questions about the plan or, more importantly, constructive ideas or suggestions regarding additional foster parent recruitment and retention strategies, we would be happy to hear from you and discuss ways in which the OCA could be of assistance toward that end. You should also be aware that the preliminary findings of the recent CFSR rated our foster parent

licensing process and standards as an area of strength. However, as you also know, to avoid any appearance of a conflict of interest, we are now outsourcing the licensing of all employees who wish to be foster parents.

Lastly, your letter asks when I first became aware of your 2003 report and mistakenly seems to assume that your report would have--or should have--been provided to me at that time in my capacity as Director of the Legal Division. However, I was not in receipt of your 2003 report prior to your recent letter, and I suspect I was not on the distribution list because the report did not raise specific legal questions and would not have required specific follow up from the Legal Division. However, as referenced throughout this response and in various other communications with your office, there have been many reforms since 2003 that relate to the areas noted in your report.

In closing, as I'm sure you appreciate, the Department receives many reports and recommendations from a variety of external partners and carefully reviews them along with valid studies and information from those having specific expertise in the field of child welfare. We constantly seek improvement and welcome ideas and recommendations that are driven by an accurate and informed understanding of the true scope of the Department's strengths and challenges and that are founded on evidence of proven effectiveness. Since becoming Commissioner, I have fully supported the continued use of evidence based practice and have taken the initiative to develop an agency-wide strategic plan for the Department that holds us to objective measures of accountability in conjunction with the other accountability tools we already utilize. As always, I welcome your input into that process and remain interested in your feedback as we finalize the plan.

I trust that we share the common goal of assuring the safety, permanency and well-being of the children and families we collectively serve, and it is my continued belief and hope that we can work together in an effective and collaborative way to promote these critically important outcomes.

Very truly yours,

Susan I. Hamilton, MSW, JD
Commissioner

SIH/el
Attachments

Supplemental SIU Training (in addition to full Investigations training modules)

July 24th 9-12, Best Practice- The course focuses on a review of the current investigations policy, including, but not limited to, best practice approaches to conducting an investigation and an examination of the different types of authority, with a discussion about the appropriate and inappropriate use and implications during an investigation.

July 29th 9-12, Interviewing- The course is devoted to assisting investigators in developing strategies that result in effective interviews. The course is designed to enhance investigators interviewing techniques, observational skills and overall ability to gather information in order to assess safety and risk.

July 31st 9-4, Decision Making- The course is designed to assist investigators in ascertaining the safety and risk levels associated with a referral. The course will focus on the importance of making accurate assessments based on factual interviews and collateral contacts. The course will again cover the fundamentals of Structured Decision Making with a focus on the tools used to assess for safety and risk.

August 5th 9-4, Sexual Abuse- The course is designed to further develop the skill and understanding of investigators in the area of sexual abuse. The class will assist investigators in practicing new skills and techniques needed to evaluate these cases.

Sept 3rd 9-4, Assessment Tools- The course will focus on several evidence based tools that the agency has adopted in order to maintain a higher level of practice. The GAIN SS, SDM will be reviewed in order to give investigators a clear understanding of how and why the tools are utilized. A component on critical thinking will be discussed to have participants examine their thought process and decisions when dealing with intricate cases. The genogram and ecomap will also be reviewed as another resource/tool to use when working with families in order to make sound decisions.

- B -

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

Susan I. Hamilton, J.D., M.S.W.
Commissioner

M. Jodi Rell
Governor

October 16, 2008

Jeanne Milstein
Child Advocate
Office of the Child Advocate
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Hartford, CT 06105

Re: Riverview Hospital-2nd Quarter 2008 Report

Dear Ms. Milstein:

I am writing in response to your letter outlining your 2nd Quarter 2008 findings and recommendations related to Riverview Hospital. While we were surprised by the marked departure in content and tone in this quarter's report in comparison to your prior quarterly reports, particularly given the general consistency of progress and challenges from the previous quarter, we continue to share your interest in seeing ongoing improvements at Riverview.

However, I am concerned about the connections you draw in this report between the restraint data and overall child safety and well-being. The second quarter report seemed to inappropriately equate the lack of an established trend line for restraint reduction at Riverview with a failure to meet the safety and well-being of children served there. Clearly, restraint reduction is an important goal that we share, but it is not an outcome that can or should be looked at in isolation. As you know, the outcomes for Riverview are the provision of safe and appropriate mental health services to children in a safe environment so that they achieve timely stabilization and the attendant capacity to have their needs met in a less restrictive environment.

Following the 2006 reports issued by the Department, the *Juan F.* Court Monitor and the Office of the Child Advocate (OCA), Riverview completed a detailed strategic planning document with concrete timelines and action steps. It was presented to the OCA, the staff at Riverview and the Riverview Advisory Board for comment and review prior to its adoption. The plan remains in effect and is, in large part, the basis upon which the monitoring at Riverview is founded. The deliverables associated with that document have largely been met in accordance with the projected timelines at the time it was written. It was also widely understood that the plan would not be static and would be amended, as warranted. Until this most recent report, the OCA appropriately reported on the implementation status of this plan as part of its quarterly report.

Undeniably, the progress toward restraint reduction has been less than anticipated. However, to imply that the use of restraint, in any form, equates with children at Riverview being unsafe and having their well-being jeopardized is misleading and contra to our collective goals. Children are placed at Riverview because, by definition, they pose a risk to themselves or others, and no other inpatient hospital is able to meet their clinical needs. As you know, when children exhibit such behavior, it is sometimes necessary to intervene in a manner consistent with state law and best practice to assure their safety and the safety of those around them. And, consistent with that level of intervention, there is no objective evidence to suggest that children are unsafe at Riverview. There has been no trend toward an increase in the substantiation rate of abuse or neglect or the inappropriate use of restraint or seclusion. Contrary to the assertion in your report, child injuries are not increasing. Comparison of the first quarter of 2008 with the second quarter showed 12 injuries stemming from patient to patient assault in the first quarter compared to 7 in the second. There were 21 patient injuries due to "acting out" behavior in the first quarter and 14 in the second, and there were 10 accidental injuries to patients in the first quarter compared to 6 in the second. More importantly, aggregate data regarding restraint cannot and should not responsibly be construed as defining the safety and well-being of children at Riverview. The appropriate use of such quality assurance data is to provide the impetus for further qualitative consideration. For example, an alternative view could well be that the failure to initiate necessary restraint increases patient to patient assault and/or self-injurious behavior.

Equally, this report's conclusion that the "well-being" of children at Riverview is compromised suffers from an absence of definition for the term. The report's focus on the trend line for restrictive treatment measures does not acknowledge that 27% of all such measures during the year prior to the report involved a single child. And, it is important to note that the child in question was successfully discharged to a lower level of care, and the staff at Riverview received thanks from the child's mother stating that she "loves Riverview" and that without Riverview, she doesn't know what she or her child would have done. Simply put, not all restraints are the same and not all are evidence of inappropriate intervention by child caring staff. However, the Department shares the concern that restraint may also be a re-traumatizing event for some children based upon their past experience, and that is among the reasons why we have committed to changing our methods of intervention, to directly train our staff on trauma-informed treatment and to establish a culture in which the consideration of trauma is reflected throughout the milieu. From a trending point of view, surveys of self-reports of feeling safe among children offer important insight, but they are neither sufficiently valid to be held up as evidence of the status of a child's well being nor are the responses correlated with the experience of the individual respondents as recipients or witnesses to the application of restraint or seclusion at Riverview.

I'm also troubled by the statement in your report that "DCF and Riverview may have a belief that the population of children served by Riverview is different and warrants use of restrictive interventions." There is no evidence to support that we adhere to that belief. We believe that the criteria for the placement of children into Riverview are different from that of other in-patient psychiatric units in this state based upon the acuity level of the child. That belief is factually founded in the attached level of care criteria for acute inpatient hospitalization and the heightened Special Admission Criteria for Riverview that was promulgated by the Connecticut Behavioral Health Partnership after review and approval by the statutorily established Behavioral Health Oversight Council. For that reason, the ORYX data used to compare Riverview, the only state operated psychiatric hospital in the comparison group, with other in-patient settings is useful as a benchmark but is less useful for direct comparison purposes.

This most recent report was equally imprecise in rendering the opinion that the Department as a whole is not committed to restraint reduction. There is full commitment to restraint reduction at the Department's state operated, behavioral health facilities. As you know, training was provided in 2006 to all of the Directors and key staff at our 3 facilities through the National Association of Mental Health Program Directors (NAMHPD), and we currently fund ongoing consultation to those facilities through a contract with one of the original NAMHPD trainers. Under my administration, the Department has also extended its efforts by initiating work with the Children's League of Connecticut and the Connecticut Association of Non-Profits to work on definitions and procedures pertaining to restraint and seclusion that will be incorporated into agency policy and program oversight activities across state operated and licensed facilities. Concurrently, the Department also engaged the same provider groups in the establishment of a set of mutually agreed upon outcomes by which programs would be evaluated. The frequency of restraint is among the outcome indicators, but it may be instructive to note that the consensus of the group did not result in restraint being considered to be an indicator that stood in isolation or even as the single most important outcome indicator of a child's safety, well-being or experience while in care.

To assure a balanced perspective regarding the use of restraint at Riverview, it would seem to be important to note that mechanical restraint has been eliminated from 4 units at Riverview. Moreover, the hospital has not used 2 point restraint anywhere on campus for more than a year. To date, the efforts at Riverview to use risk management techniques and supervision, coupled with a well articulated goal to reduce restraint, have been extraordinary. Restraint and seclusion data is regularly reviewed at all levels of the organization from the Hospital Executive Committee to the supervisor of the individual line worker. It is trended by unit, shift and worker. There is a continual process to do post-hoc review to assess the antecedent events to consider whether an alternative intervention at a different point in the pattern of the escalating behavior that resulted in the restraint might have avoided the need for the restraint.

However, we recognize that efforts are not the same as success. The need for and use of restrictive treatment measures are exceptionally complex and involve patterns of behaviors that have been learned by staff and patients. The Department utilizes a "Plan - Do - Check - Act" paradigm of quality improvement, and we agree that it is important to turn the data and discussion into tangible action steps as we learn that an intervention is not producing the anticipated or desired results. The Riverview administration committed itself at the June Implementation Committee meeting to reformulation of the strategic plan with emphasis on baseline and targeted goals. That work commenced with the September meeting of the committee. The commitment to modification and implementation of changes in procedure at Riverview continued subsequent to the release of the July report. For example, the report referenced the Emergency Safety Intervention form, which has now been fully implemented as an additional assessment tool. Similarly, your reference that the risk assessment tool was being piloted but had not been fully evaluated or implemented failed to note our identification and plan to implement other more effective tools. In addition, the report did not acknowledge the implementation of the new milieu progress note requirements within the nursing department designed to present a more qualitative progress note on each child's accomplishment of their treatment plan goals or the implementation of the Situation Incident Report (SIR) response note designed to standardize documentation of acute responses to children in distress.

Riverview collects extensive data, and some of that data was used for content in your most recent report. Multiple committees meet on a regularly scheduled basis to review data and trends and to initiate practice change intended to address areas in which performance is not producing results consistent with the strategic plan. The improved communication and engagement of staff at all levels of the hospital is well documented. Training has been increased and enhanced in content, and a specific training curriculum with a focus on improved supervision is under development. These activities when considered in conjunction with the progress on the strategic plan display a fundamental emphasis on quality improvement. The following is a small sample of the quality improvement processes already in place:

- All standing committees have established performance improvement goals and measures with the results published quarterly.
- The review of the risk management areas are integrated into the daily operations of the hospital.
- There are multiple risk management areas that are reviewed and discussed by multiple levels of staff at Riverview, including:

    - Environment of Care meetings
    - Nursing Leadership meetings
    - Medical Executive Committee meetings

- Psychiatry Department meetings
- Program Operations weekly meetings
- Executive Committee weekly meetings
- Implementation Committee monthly meetings
- Unit Leadership meetings
- Pharmacy and therapeutic meetings
- Infection control meetings

- The systematic review of incidents occurs on an on-going basis as follows:

  - Incident reports are generated at the time of the incident.
  - They are reviewed by QA staff daily and separated as to level of severity.
  - Serious/Critical or repeated incidents are referred to the Director of Program Operations, Program Managers, Directors of Nursing, Medical Director, Superintendent and Assistant Superintendent, dependent on the nature of the incident.
  - Employee incidents regarding concerns of inappropriate performance are referred to Human Resources in addition to that employee's direct Manager.
  - The Director of Program Operations and the Medical Director review every restraint review form.
  - Program Managers conduct reviews on restraints occurring on their units. The reviews are documented using a restraint review form and then discussed with the individuals involved in the restraint. The process is intended to provide dialogue around the restraint/seclusion and the alternative methods that could be used to prevent the incident.
  - Two physical interventions within 12 hours or those that last longer than 4 hours entails review of the incident by the Medical Director with the authorizing physician.
  - The Hospital conducts "root cause analysis" on significant events.
  - Medical staff has peer review on a quarterly basis to increase the quality of clinical care throughout the hospital.

In addition, Riverview, notably including its Quality Improvement Division, is fully accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the national standard for hospital accreditation. Accordingly, it is quite difficult to understand the basis by which the OCA could credibly hold JCAHO's opinion subordinate to its own when evaluating Riverview's quality improvement processes.

With regard to cost, there is no doubt that Riverview is expensive, and this has always been the case. The Comptroller issues the cost report on an annual basis. In looking at the cost for the last 5 consecutive years, the largest increase in the cost corresponded to

the decision to reduce the census at Riverview following the above-referenced 2006 report, which decision was jointly supported by the Department, the *Juan F.* Court Monitor, and the OCA. The omission of any reference to that recommendation and its correlation with the increase in cost appears to have been an oversight in your most recent report, but I am committed to the prudent expenditure of state funds and welcome any tangible suggestions for savings that you believe might be effected at Riverview. As over 80% of the cost is in personal services, the opportunities for saving appear limited short of staffing reductions. Your report did not indicate if you were suggesting such a step or if you believed that the staffing levels are excessive.

I am pleased to note that to date the Riverview Monitor and the process she has employed has been considered an asset by me and Riverview. Her reports have been balanced and her criticism constructive. For example, we agree completely that more must be done to engage children, family and DCF workers in the treatment planning process. Prompted by the Monitor's feedback, a review of the data collection instrument was completed; and it was found to be flawed in that it did not reflect the participation of those arriving late to meetings or those that participated by telephone. Steps have already been taken to address the data collection, and increased efforts are underway to emphasize the importance of participation in planning among area office staff.

As the next quarterly report draws near, I anticipate that it will reflect the continued improvement and changes that have occurred subsequent to the release of the last report. The construction of the most recent report stood in stark contrast to the Riverview Hospital that is a sight for continuing education units for nurses and psychiatrist; affords internship for multiple professional degrees; and that has established partnerships with Yale University, Yale Child Study Center and the UConn Health Center. I do not see a hospital in crisis that is in any way jeopardizing the safety or the well-being of the children it serves. Instead, I see Riverview as a quality and necessary resource for the children of CT whose needs cannot be met in any other setting. The change in culture in the very short period time since the joint issuance of the 2006 report is remarkable, and the dedication and commitment of the staff to the mission of the hospital, to the achievement of the strategic plan and to delivering the best possible care for children is commendable.

I trust that you agree that a balanced perspective is an important component of effective advocacy. It appears that we would mutually benefit from the establishment of defined and agreed upon measures of outcomes related to Riverview as a basis upon which we share well-defined terminology and objective assessment of performance. Ideally, the Riverview Monitor would be in a position to facilitate that discussion with the Riverview administration as part of the strategic planning process with the results being open for our respective review. I believe that would result in the most constructive approach for the

remainder of the monitoring period. I look forward to those discussions and our continued work together.

Sincerely,

Susan I. Hamilton, MSW, JD
Commissioner

cc: Karl Kemper, Chief of Staff
Peter Mendelson, Bureau Chief, Behavioral Health and Medicine
Joyce Welch, Superintendent, Riverview Hospital

A. ACUTE INPATIENT PSYCHIATRIC HOSPITALIZATION

Definition

Inpatient treatment services in a licensed general, psychiatric hospital or a state operated psychiatric hospital offering a full range of diagnostic, educational, and therapeutic services with capability for emergency implementation of life-saving medical and psychiatric interventions. Services are provided in a physically secured setting. Patient admission into this level of care is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. This service is generally used when 24-hour medical and nursing supervision are required to provide intensive evaluation, medication titration, symptom stabilization, and intensive brief treatment.

Authorization Process and Time Frame for Service

This level of care requires prior authorization. The first authorization is for up to 3 days. Subsequent authorizations are based on the individual needs of the patient with consideration of the physician's recommendations. Admissions to Riverview Hospital shall be reviewed for medical necessity and will require concurrent reviews on a periodic basis to facilitate discharge planning.

The first 30 days of Court ordered admissions to Riverview Hospital shall be deemed medically necessary and so authorized. Such stays shall be subject to clinical review 21 days post admission to assist with timely discharge planning. Any court ordered stay beyond 30-days shall require prior authorization and be authorized for up to seven days.

Level of Care Guidelines

A.1.0 Admission Criteria

A.1.1 Symptoms and functional impairment include all of the following:

A.1.1.1 Diagnosable DSM Axis I or Axis II disorder,

A.1.1.2 Symptoms and impairment must be the result of a psychiatric or substance abuse disorder, excluding V-codes,

A.1.1.3 Functional impairment not solely a result of Pervasive Developmental Disorder or Mental Retardation, and GAF <30

A.1.2 Presentation consistent with at least one of the following Symptom Categories:

A.1.2.1 Current risk of suicide/self-injury: Imminent risk of suicide or self-injury, with an inability to guarantee safety in a less restrictive environment as manifested by:

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

A.1.2.1.1 Attempt: Recent and serious suicide attempt indicated by degree of lethal intent, impulsiveness of actions and/or concurrent intoxication. Inability to reliably contract for safety; or

A.1.2.1.2 Intent/Plan: Current suicidal ideation with well formulated plan, imminent intent to act and available means that is severe and dangerous with minimal expressed ambivalence or significant barriers to doing so; or

A.1.2.1.3 Self-mutilation: Recent self-mutilation that is severe and dangerous, e.g., deep cuts requiring sutures, 2nd to 3rd degree burns, swallowing objects; or

A.1.2.1.4 Hallucinations and/or Delusions: Recent command/threatening hallucinations or delusions that threaten to override usual impulse control and likely to result in harm to self or others; or

A.1.2.1.5 Extreme recklessness/agitation/impulsivity: Repeated pattern of reckless behavior suggesting an inability or unwillingness to consider potential for risk to self (e.g. extreme scratching, inserting objects, driving while intoxicated, driving without a license, running into traffic; hanging from a moving car; jumping from high places, dangerous use of substances, provocation of others, flagrant exposure to victimization, and other potentially highly self injurious or lethal risk-taking behavior).

A.1.2.2 Current risk of homicide/danger to others: Imminent risk of homicide or harm to others with inability to guarantee safety in a less restrictive environment as manifested by:

A.1.2.2.1 Attempt: Recent and serious homicide attempt indicated by degree of lethal intent, impulsivity and/or concurrent intoxication, severe and dangerous, or inability to reliably contract for safety or a history of serious pat attempts that are not of a chronic, impulsive, or consistent nature; or

A.1.2.2.2 Intent/Plan: Current homicidal ideation with well formulated plan, imminent intent to act and available means that is severe and dangerous with minimal expressed ambivalence or significant barriers to doing so; or

A.1.2.2.3 Severe assault: Recent physically assaultive behavior with a high potential for recurrence and high potential for serious injury to self or others; or

A.1.2.2.4 Hallucinations and/or Delusions: Recent command/threatening hallucinations likely to result in harm to self or others; or

A.1.2.2.5 Extreme recklessness/ /impulsivity: Sustained reckless or impulsive behavior suggesting an inability or unwillingness to consider potential for serious risk to others (e.g. fire setting, sexual abuse, reckless driving, and other risk-taking behavior); or

A.1.2.2.6 Agitation/Aggression: Sustained agitated and uncontrolled behavior including acts of violence against property or persons with high risk of recurrence.

A.1.2.3 Gravely Disabled: Acute and serious deterioration from baseline in mental status and level of functioning resulting in high risk of harm to self or others. Severe impairment of activities of daily living skills and not secondary to abuse or neglect as evidenced by one or more of the following:

A.1.2.3.1 Evidence of severe neglect of personal hygiene (i.e. highly malodorous, parasitic infestation, poor/no oral hygiene, grossly soiled clothing, inability to manage toileting tasks appropriately) despite appropriate and repeated attempts by caretakers to alter behaviors; or

A.1.2.3.2 Malnutrition of life-threatening severity and/or highly compromised nutrition or eating patterns (i.e. eating only food packaged in cellophane, eating only peas counted out one by one) which may be related to paranoid, delusional, or severe eating-disordered beliefs or rituals; or

A.1.2.3.3 Immobility with potential to compromise physical status; or

A.1.2.3.4 Unable to communicate basic needs or

A.1.2.3.5 Catatonia; or

A.1.2.3.6 Severe psychomotor agitation (inability to sit still not related to ADHD or medication side effects;

several nights without sleeping due to emotional agitation and/or delusions or paranoia; emotional lability with persistent pacing, with or without property damage, unresponsive to support or limits from others); or

A.1.2.3.7 Response to command/threatening hallucinations which could result in harm to self/others; or

A.1.2.3.8 Response to delusions, excessive preoccupations, or developmentally inappropriate inability to sort out fantasy from reality, which interfere with functioning and places child or others at risk (i.e., paranoid ideas that inspire retaliation; delusions of invincibility that lead child to place self in harm's way (e.g., slicing arm open to fix wires like "The Terminator"); or

A.1.2.3.9 Disorientation to person, place and time; or

A.1.2.3.10 Delirium; or

A.1.2.3.11 Dissociative events, which could result in harm to self/others.

A.1.2.4 Acute Medical Risk: Imminent risk for acute medical status deterioration due to the presence and/or treatment of an active psychiatric symptom(s) manifested by:

A.1.2.4.1 Signs, symptoms, and behaviors that interfere with diagnosis or treatment of a serious medical illness requiring inpatient medical services (e.g., endocrine disorders such as diabetes and thyroid disease; cardiac conditions; etc.); or

A.1.2.4.2 A need for acute psychiatric interventions (i.e., drug, ECT, restraint) that have a high probability of resulting in serious and acute deterioration of physical and/or medical health; or

A.1.2.4.3 Not eating and/or excessive exercise to the point that further weight loss is medically threatening.

A.1.2.5 Medication Adjustment: Patient has met any of the above symptoms within the past 12 months and requires a medication taper and re-evaluation in an inpatient hospital setting. Previous attempts to taper medication have resulted

in behavioral escalations that meet admission criteria for inpatient hospitalization.

And meets at least one of the following criteria:

A.1.3 Intensity of Service Need

A.1.3.1 Individual requires inpatient psychiatric care with 24-hour medical management. The above symptoms cannot be contained, attenuated, evaluated and treated in a psychiatric residential treatment facility or lower level of care as evidenced by:

A.1.3.1.1 Psychiatric treatment (e.g., medication, ECT) presents a significant risk of serious medical compromise (e.g., ECT for a child with a cardiac condition, restraint or seclusion of a child with a cardiac condition, initiation of or change in neuroleptic medication for a child with history of neuroleptic malignancy syndrome, or administration of depakote to a child with a history of neutropenia); or

A.1.3.1.2 Patient requires or is likely to have diagnostic or evaluative procedures readily available in a hospital setting (e.g., MRI, 24-hour EEG, neurological examination, or specialized lab work, etc.); or

A.1.3.1.3 Intrusive route of medication administration requires medical management (e.g., intramuscular administration of PRN medication or administration by means of an NG tube); or.

A.1.3.1.4 Patient has had frequent (e.g., once every other day) restraints or seclusions or has recently had mechanical restraint; or

A.1.3.1.5 The administration of restraints or seclusions has required the involvement of three or more persons or presented high risk of serious injury to self or others; or

A.1.3.1.6 Patient requires 1:1 supervision or frequent checks for safety (e.g., every 15 minutes or less); or

A.1.3.1.7 Efforts to manage medical risk symptom or behavior (see III.A.1.b.(4)) in a lower level of care

are ineffective or result in an acute escalation of behavior with risk of harm to self or others; or

A.1.3.1.8 Requires close medical monitoring or skilled care to adjust dosage of psychotropic medications and such medical monitoring and dosage adjustment could not safely be conducted in a psychiatric residential treatment facility, residential treatment center, or ambulatory setting.

A.1.4 Special Admission Criteria:

A.1.4.1 To demonstrate the necessity for admission to Riverview Children's Hospital, the patient must:

A.1.4.1.1 Meet clinical criteria for acute inpatient care **and** exhibit behaviors that pose safety concerns of a magnitude that can not be effectively managed in other inpatient settings, or

A.1.4.1.2 Require specialized treatment services not available in other acute care inpatient settings as evidenced by:

- The patient has a serious psychiatric disorder and co-occurring developmental disorder that requires intervention not otherwise available in other inpatient settings, or
- The patient has had a recent history of multiple (i.e., three or more) admissions to acute inpatient settings over the past ninety days, and is currently receiving treatment in an acute inpatient setting, and has received intensive psychiatric evaluation and treatment with not appreciable improvement in status, or
- The patient currently resides in a Residential Treatment Center or Level 2 Group Home and has demonstrated the need for an intermediate level of psychiatric care as demonstrated by a recent history of multiple (i.e., three or more) admissions to acute inpatient psychiatric settings over the past ninety days, or
- The patient currently resides in the community (e.g., foster home, relative home, biological home)

and demonstrates the need for intermediate level of hospital care as demonstrated by a recent history of multiple (i.e., three or more) psychiatric admissions over the past ninety days.

A.2.0 Continued Care Criteria

A.2.1 Patient has met admission criteria within the past 48 hours or has been prevented from engaging in qualifying behavior due to use of 1:1 supervision, frequent checks (q5), physical/mechanical restraint, or locked seclusion; or

A.2.2 Evidence of active treatment and care management as evidenced by:

A.2.2.1 Patient and family participation in treatment consistent with care plan, or active efforts to engage the patient and/or family are in process. Type, frequency, and intensity of services are consistent with the treatment plan, and

A.2.2.2 A care plan with evaluation and treatment objectives appropriate for this level of care has been established. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored daily, and

A.2.2.3 Vigorous efforts are being made to affect a timely discharge (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying and referring for aftercare or local systems of care or local DCF Managed Service System, scheduling initial aftercare appointments).

A.2.3 If the patient does not meet criterion A.2.1, continued stay may still be authorized under any of the following exceptional circumstances:

A.2.3.1 Patient has clear behaviorally defined treatment objectives that can reasonably be achieved within 30 days and are determined necessary in order for the discharge plan to be successful, and there is no other suitable environment in which the objectives can be safely accomplished; or

A.2.3.2 Patient can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the patient to be discharged directly to the community rather than to another institutional setting; or

A.2.3.3 Patient is expected to transfer to another institutional treatment setting within 30 days of discharge and continued stay at this level of care, rather than an interim placement, can avoid disrupting care and compromising patient stability. Continued stays for this purpose may be as long as 30 days; or

A.2.3.4 Patient is scheduled for discharge, but the patient's community-based aftercare plan is missing critical components. These components have been vigorously pursued but are not available (including but not limited to such resources as placement options, psychiatrist or therapist appointments, day treatment or partial hospital programs, etc.). Authorization may be extended for up to 30 days. In such cases, if it is reasonably determined that critical component of the discharge plan will not be available within 30 days, the patient should be discharged to a less restrictive level of care.

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

1) Those mitigating factors are identified and
2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Susan I. Hamilton, J.D., M.S.W.
Commissioner

M. Jodi Rell
Governor

October 14, 2008

Jeanne Milstein, Child Advocate
Office of the Child Advocate
999 Asylum Avenue
Hartford, CT 06105

Dear Ms. Milstein:

I am writing in response to your letter and briefing paper concerning girls who are incarcerated at the York Correctional Institution (YCI) pursuant to orders issued by the adult criminal court. While I certainly share and appreciate your interest in reducing the need for adult correctional settings for all youth, I think it's important to clarify some misleading assumptions referenced in your paper regarding existing law and the Department's role and responsibility in this area before responding to some of your findings and recommendations.

First, let me say that the Department of Children and Families (DCF or Department) fully agrees with and supports your desire "to stem the pipeline to prison for all girls" and boys. And, while we share your view that "adolescents are children and children do not belong in adult facilities," all youth who commit crimes at the age of 16 or older, and 14 and 15 year olds who commit violent crimes, are currently subject to prosecution and incarceration only through the adult criminal justice system in accordance with existing Connecticut law. Fortunately, as you know, many of these youth will be served through the juvenile court system when the jurisdictional age change takes effect in January 1, 2010. Even then, however, adolescents who commit serious offenses will continue to be the responsibility of the adult criminal justice system and may be subject to incarceration in adult correctional facilities.

Second, as I assume you know, DCF is not a legal party in adult criminal cases and generally has little, if any, involvement in those cases unless they involve a youth who is already committed to DCF. DCF cannot and does not place youth at YCI or any other adult correctional setting as that authority is vested solely with the adult criminal court, and I am confident that the Department of Correction (DOC) remains committed to meeting the needs of all youth who are placed in their custody at YCI and Manson Youth Institute (MYI). In fact, as you know, DCF works very closely with DOC toward that end and has out posted staff to work at YCI and MYI to assist with treatment and discharge planning, particularly for those youth who are committed to or involved with DCF. This is discussed more fully below.

Third, I would be remiss if I didn't comment on your implication that if DCF had done a better job with those girls currently at YCI, who may have had some prior DCF involvement, that would have prevented them from engaging in the behavior that led to their incarceration. I wish the complexity of this issue was that simple, and I am concerned with your assumption that this premise applies regardless of how long ago DCF was involved and for what period of time. While your paper seems to inappropriately group all prior "DCF involvement" into the same category, it's important to note that our involvement with a family can often include just an investigation which may last less than 30 days and may have occurred many years ago with no recent open case. While that's not always the case, it's an important distinction that needs to be made to assist us in appropriately and intelligently targeting any necessary systemic changes.

Fourth, in terms of providing a more accurate context for this discussion, I need to highlight some data that was unfortunately overlooked in your paper. While there are currently only 4 girls at YCI who are committed to DCF (out of a total of 22 girls) and just 6 others whose families have a current open case with the Department, the Department is also serving over 2400 additional girls ages 15 or older either at home with their families, in foster care or in other community-based placements. Interestingly, using your own analogy, one could argue that the Department has, therefore, successfully provided services to those girls at the "front end" preventing the need for incarceration at YCI. However, as noted above, I believe that type of causal analogy is overly simplistic and ignores a host of other variables that impact this complex issue.

Lastly, your frequent reference to DCF not responding to your office is puzzling. As you know, we meet on a monthly basis to discuss issues of mutual concern. I am also aware that members of your staff have regular meetings with members of my Executive Management Team, our staff sees and talks with each other at various meetings and case conferences, and, as always, your office is in constant contact with the DCF Ombudsman's office. While our offices may not be in agreement on all issues, your frequent requests for information, documents and meetings are seen as important and responded to in a timely manner from our perspective.

With those general clarifications, I would like to take this opportunity to describe some of the steps the Department has taken, is currently taking and plans to take in order to meet the needs of adolescents who come to the attention of the Department and are at risk of arrest and/or incarceration in a DOC facility, particularly girls who are at YCI. While I suspect you may be aware of some of these activities, I will reiterate them here as most were not mentioned in your paper.

The Department is committed to and has expanded gender responsive services throughout its service array. More specifically, all of the Department's contracts with group home providers require the programs to be gender responsive and as contracts are entered into

with residential providers, they will include a similar requirement. The providers' adherence to these requirements is reviewed and monitored as part of the Department's licensing and contractual oversight responsibilities. In addition, the Department has transformed the emergency shelter system from co-ed programs to the Short-Term Assessment and Rehabilitation (STAR) model. These programs also provide gender specific programming for all girls and are required to train staff in gender responsive services. The Department has also added two group homes specifically for pregnant girls and continues to work with these programs to increase their ability to engage and treat those girls based on their unique needs. And, the Program Guidelines for Girls' Services, issued as part of the DCF-CSSD Girls' Programs Standards and Certification Project in May of this year, have recently been distributed for implementation to the three residential programs designed to serve girls on parole. This will be supplemented by the re-design of a female-responsive parole system using the Court Support Services Division model, adapted by Parole Services, which is currently underway with a planned implementation date of January 1, 2009.

During the past several years, the Department has also expanded the types of Evidenced Based community and home-based services available to children and families throughout the state. These models of service delivery have been proven effective with both girls and boys who are involved with, or at risk of becoming involved with, the juvenile justice system. Examples of such services include, but are not limited to, Functional Family Therapy (FFT) and Multi-Systemic Family Therapy (MST). More specifically, these interventions have resulted in reduced recidivism and other positive and measurable outcomes for youth. Similarly, Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) training has been provided to several programs throughout the state and to staff at the four DCF facilities in response to the prior reports you mention in your paper. This has included staff at outpatient clinics, group homes, residential programs and the DCF facilities who have direct contact with children. A Train-the-Trainers model is being used to ensure newly hired staff receives this training as well. And, I am pleased to note that the Ansell Casey Life Skills Program will soon be provided throughout our continuum of care for all girls in the juvenile services system with training beginning in November.

Also, the Bureau of Behavioral Health is presently evaluating behavioral health and trauma screening tools for use with all children involved with DCF. A decision on which tools to use and an implementation plan will be completed by the end of this year. This will be integrated with existing assessment tools to ensure that all children and youth receive the same thorough assessment and identification of needed services, gender-specific or otherwise, regardless of the underlying reason for DCF involvement. As your paper recommends, this is being driven by gender-responsive and trauma-informed best practices.

In addition, as noted above, the Department continues to work closely with DOC to meet the needs of adolescents when they are incarcerated in an adult facility. As you described, this relationship has continued to evolve over time as reflected in the revised DCF/DOC Memorandum of Understanding and as witnessed in the various meetings (MAWGY, SHE-MAWGY, JO/LO) and case conferences that both Departments attend.

In support of these efforts, as referenced above, the Department has assigned and out posted social work staff to both YCI and MYI. The role and responsibility of these staff varies based on the legal status of each adolescent. For example, the Department's ability to share information and develop plans for a girl at YCI is clear when the girl is committed to DCF, and DCF is the legal guardian. However, when a case is open for services but the girl is not committed to DCF, or when there is no open DCF case, DOC must work with the girl's parent(s) or legal guardian(s) to effectuate treatment and discharge planning. In those cases, DCF's role may be more limited.

The DCF staff at YCI and MYI are notified of all admissions and provide case management and other services as outlined in the DCF/DOC Memorandum of Understanding and applicable DCF policy. When DCF is the girl's guardian, they review the DCF record and provide the Mental Health Unit at YCI with a written summary to assist in meeting the girl's needs at YCI and to facilitate the integration of DOC and DCF treatment planning along with the assigned DCF social worker. In addition, the DCF staff at YCI see each girl who has an open DCF case on a weekly basis and assist the girls with making telephone contact with family members, their attorneys and their assigned DCF social worker. DCF staff also attend weekly meetings at YCI in which each girl is discussed by representatives from YCI mental health unit, medical, educational and custodial staff.

It is also necessary to note here that DCF records show that the majority of the girls at YCI have been charged with some type of assault in contrast to your statement that "the majority of the girls at YCI are charged with violations of probation orders due to excessive truancy from school, running away from their residential treatment placements and fighting and aggressive behavior while receiving mental health treatment at residential programs and hospitals." These charges vary based on the extent of any injuries and the girl's relationship to the victim. Many of the victims were family members or peers or staff at residential facilities. More specifically, of the 22 girls currently at YCI, one has a pending murder charge and others are charged with crimes including assault, drug possession, larceny, burglary, home invasion and risk of injury to a minor. In addition, while some girls are at YCI for an extended period based, in part, on the seriousness of their charges, most others are released within two weeks of their admission. Many of these girls return home and some continue to receive services from DCF to assist in their re-entry into the community. And, in order to further assist with planning for DCF involved girls who are sent to YCI, DCF will be administering the

Youth Compass, a validated tool used to assess both risk and needs, to all DCF involved girls currently at YCI in the next few weeks. This will also be used on an ongoing basis for all DCF involved girls incarcerated at YCI to assist with their treatment and discharge planning.

The Department shares your concern about the lack of documentation in some DCF records and the need to improve the quality of our treatment planning process, and these areas are currently being addressed through a host of activities, including, but not limited to, implementation of the recent agreement related to the *Juan F.* Exit Plan. I believe you have a copy of that agreement, and I'd be happy to talk with you about our progress on that during one of our upcoming monthly meetings if you think that would be useful. In the meantime, I am confident that we will continue to see improvements in both the quality of our treatment plans and the timely provision of needed services, particularly for children and youth in foster care.

DCF also continues to work with the other state agencies and stakeholders with responsibility for children in a number of areas including the collaboration and meetings referenced above with DOC, the Joint Juvenile Justice Strategic Planning Committee with the Judicial Branch, CSSD and others, the Family with Service Needs (FWSN) Advisory Board, the Juvenile Justice Policy Oversight Coordinating Committee (JJPOCC) and the Criminal Justice Planning and Advisory Council (CJPAC). These groups have looked at the connection between issues such as truancy, poor school performance and other variables as precursors to delinquent behavior, and the Department remains actively involved in the development and implementation of applicable recommendations that have arisen from these collaborative efforts.

Further, I need to clarify that the position of "Director of Girls Services" has not been moved to Juvenile Services. Rather, the former Director moved to a position within the Bureau of Juvenile Services in order to focus on the development of gender specific services for the secure facility for girls and to ensure that a continuum of gender responsive services are available to girls in the entire juvenile justice system. However, because we recognize the importance of gender-responsive services for all youth served by the Department, not just juvenile justice youth, our planned restructuring will include this area of work under our Division of Strategic Planning, with a focus on agency-wide integration of the recommendations that recent reports on this issue have generated.

Lastly, much of the information that you suggest should be collected and analyzed by the Department related to demographics, available services and placements is already available to and used by the Department, along with individual case information, as a basis for proactive planning and response. Similarly, we believe our revised Foster Care Plan, recently approved by the Center for the Study of Social Policy, will support and enhance our ability to meet the unique needs of girls in foster care. In addition, the

Department already evaluates and provides ongoing oversight of all licensed programs, including girls' programs, and staff adherence to all agency policies, procedures and interagency agreements is a regular part of supervision and, if necessary, the progressive discipline process. However, I will address your particular concern about adherence to the DCF/DOC Memorandum of Understanding and applicable DCF policy with my Executive Management Team and will direct them to follow up with their staff across all DCF Bureaus as needed to ensure compliance. And, of course, the Department will fully support and work with DOC in its efforts to implement the DOC recommendations outlined in your paper.

Thank you for sharing your views and suggestions. I look forward to working with you and others in our collective efforts to improve services and outcomes for all youth receiving services throughout the system.

Sincerely,

Susan I. Hamilton, MSW, JD
Commissioner

cc: Theresa C. Lantz, Commissioner, Department of Correction